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IN THE

United States Supreme Court

CLINTON SEWELL, M.D.
CARICARE MEDICAL SERVICES, P.C.,

Petitioners,

v.

THE 1199 NATIONAL BENEFIT FUND FOR
HEALTH AND HUMAN SERVICES,

Respondent.

On Petition for a Writ of Certiorari
To The United States Court of Appeals for the Second Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the Second Circuit erred in affirming the respondent's failure to follow the statutory requirements regarding notification and appeal process of withheld benefits was not prejudicial to petitioners' right to be compensated for services rendered.

2. Whether the Second Circuit erred in affirming the use of the arbitrary and capricious standard as opposed to the abuse of discretion standard without consideration of the issue of conflict of interest in holding that the respondent was correct to withhold and subsequently recoup payments to petitioners.

3. Whether § 502 (a) (3) of the Employee Retirement Income Security Act of 1974 (ERISA), 88 Stat, 29 U.S.C. § 1132(a)(3) (1994 ed.), authorizes respondent to recoup money from current beneficiaries for overpayment of benefits paid to petitioners from prior claims submitted on behalf of other beneficiaries.

PARTIES TO THE PROCEEDINGS

Petitioners Clinton Sewell, M.D. and Caricare Medical Services, P.C., as assignees of valid forms of assignments from members of Respondent's health plan, were the plaintiffs and appellants in the District Court and Second Circuit Court of Appeals proceedings, respectively.

Respondent The 1199 National Benefit Fund for Health and Human Services, a multi-employer trust fund established in accordance with Section 186(c) of the Labor Management Relations Act, 1947, an "employee welfare benefit plan" as that term is defined in the Employees Retirement Security Act of 1974 ("ERISA"), and a Voluntary Employee Beneficiary Association, as that term is defined in Section 501(c)(9) of the Internal Revenue Code, was the defendant in the District Court proceedings and respondent in the Second Circuit Court of Appeals proceedings.

CORPORATE DISCLOSURE STATEMENT

Pursuant to the Rule 29.6 of the Rules of this Court, petitioner Caricare Medical Services, P.C. states the following:

1. Caricare Medical Services, P.C. is not a publicly held corporation or other publicly held entity.

2. Caricare Medical Services, P.C. has no parent corporations and no publicly held corporations own 10% or more of its stock.

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OPINIONS BELOW

The opinion of the Second Circuit of Appeals is unpublished. The relevant order of the district court is unpublished.

STATUTORY PROVISIONS INVOLVED

29 U.S.C. § 1001(b) provides in pertinent part, "It is hereby declared to be the policy of this chapter to protect. . . .the interests of participants in employee benefit plans and their beneficiaries."

29 U.S.C. § 1104(a)(1) provides in pertinent part, "a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries."

29 U.S.C. § 1132(a) provides in pertinent part, "A civil action may be brought—(1) by a participant or beneficiary—. . . (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."

29 U.S.C. § 1132(a)(3) authorizes a civil action:

> "by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of . . . the terms of the plan."

29 U.S.C. § 1132(f) Amount in controversy; citizenship of parties.

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or

the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

29 U.S.C. § 1133 In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1144(a) Supersedure; effective date.

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003 (a) of this title and not exempt under section 1003 (b) of this title. This section shall take effect on January 1, 1975.

29 C.F.R. § 2560.503-1(g) Manner and content of notification of benefit determination. (1) Except as provided in paragraph (g)(2) of this section, the plan administrator shall provide a claimant with written or electronic notification of any adverse benefit determination.

29 C.F.R. § 2560.503-1(h) Appeal of adverse benefit determinations. (1) In general. Every employee benefit plan shall establish and maintain a procedure by which a claimant shall have a reasonable opportunity to appeal an

adverse benefit determination to an appropriate named fiduciary of the plan, and under which there will be a full and fair review of the claim and the adverse benefit determination.

(2) Full and fair review. Except as provided in paragraphs (h)(3) and (h)(4) of this section, the claims procedures of a plan will not be deemed to provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination unless the claims procedures--

(i) Provide claimants at least 60 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;

(ii) Provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(iii) Provide that a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section;

(iv) Provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

JURISDICTION

The court of appeals entered its judgment on June 14, 2006. The court of appeals denied the petition for rehearing on October 31, 2006. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT OF CASE

The basis of jurisdiction in the court of first instance was conferred by ERISA § 2, 29 U.S.C. § 1001(b), ERISA § 502, 29 U.S.C. § 1132(a), ERISA § 502, 29 U.S.C. § 1132(f) and 29 U.S.C. § 1144(a). Petitioners are assignees of benefits otherwise payable to eligible members and their dependents participating under Respondent's employee health benefits plan, as said health benefits are more particularly described in the Respondent's Summary Plan Description.

The Employee Retirement Income Security Act of 1974 (ERISA) provides a full and fair review of the decision following a denial of benefits under an ERISA health care benefits plan. 29 C.F.R. 2560.503-1(h) Failure to provide a full and fair review of denied benefits allows participants the right to commence a civil action in federal court against their Plan. *See* 29 U.S.C. § 1132(a) Petitioner, having received valid assignments of payment from respondent's members, filed suit in the United States District Court for the Southern District of New York against respondent, the 1199 National Benefit Fund for Health and Human Services (the "Fund") when it began a de facto denial of claims submitted for payment by withholding payments due Petitioners. Petitioners contend that the Fund's indefinite withholding of payment without due

process was not consistent with the ERISA regulations that govern the Fund. Further, both withholding and recoupment of payments are impermissible under ERISA and caused substantial injury to the petitioners. The Fund's defense was that under a claims review system it had constructed in 2003, petitioner had been overpaid by $133,167.00 for services provided between 1999 and mid-2003, and its action of indefinite withholding of payment due to petitioners for claims submitted in the latter part of 2003 to 2005, while demanding full restitution without permitting access to an internal review process, was not an arbitrary and capricious act, but a reasonable decision arrived at after several internal meetings by its fraud and abuse committee created after it entered into contract with petitioners.

Respondent Fund used a claims review process to target 70 participating physicians including petitioners in a manner that was contrary to ERISA, the terms of the Physician Participation Agreement, Respondent's Medical Provider Manual, and Summary Plan Description. The written agreement provided for review of claims by a utilization review program (as defined in Respondent's Medical Provider Manual) prior to the payment of claims. Between 1999 and 2003, claims were paid by Respondent consistent with the terms of its Medical Provider Manual. The newly-created claims review system was implemented without notice and was performed by its Fraud and Abuse Committee.

Unlike the utilization review program which, according to Respondent's Medical Provider Manual, consisted of doctors and nurses, the Fraud and Abuse Committee consisted of employees of respondent, including its medical

director. The Fraud and Abuse Committee did not review claims but used a mathematical analysis to ascertain the validity, or lack thereof, of the code selection promulgated by American Medical Association's Current Procedural Terminology (CPT) and used by Petitioner on claim forms submitted to respondent in order to identify the medical services provided to the Fund's members. It is this analysis that the Fund, seeking to be reimbursed for claims already submitted and approved pursuant to the terms of its Medical Provider Manual and paid according to its fee schedule of allowances for the years 1999 to July 2003, withheld payment of claims for the latter part of 2003 to 2005.

The District Court found, as a matter of fact, that the petitioners submitted claims for payment with higher CPT codes than was warranted. The district court did not, as a matter of fact, make a finding as to whether the services provided to the patients were consistent with the CPT code selection or whether the CPT code selection complied with the American Medical Association's Evaluation and Management Guidelines because respondent had not compiled an administrative record of the disputed claims. Nonetheless, the District Court found, as a matter of fact, that the Fund was correct to "downcode" each and every claim submitted by petitioners by one level in order to approximate the correct CPT code for the actual services rendered by petitioners. Without the benefit of an administrative record, the District Court, while acknowledging that the constitution and convention of the Fraud and Abuse Committee were contrary to the relevant provisions of ERISA, the mandated provisions of the plan, and the agreement circumscribing the relationship between petitioners and respondent, held that respondent's actions were reason-

able, that is, not arbitrary and capricious. In addition, the District Court held that the Fund was correct to recoup overpayments allegedly made on earlier claims by using the payments due on subsequent claims.

Notably, the District Court did not analyze the issue of conflict of interest raised in the pleadings and the evidence led by petitioners during the trial.

The Second Circuit affirmed the decision of the district court judge. The court reasoned that the terms of the Plan permit the Fund to withhold benefits where the beneficiaries do not repay the Fund for benefits that they were not entitled to. Further, the Fund has a fiduciary duty to ensure that the plan receives all funds to which it is entitled. In the circumstances, the Fund had the duty and authority to recoup the overpayments and the actions of the Fund were reasonable given the inherent difficulties posed by a more individualized inquiry.

REASONS FOR GRANTING THE WRIT

This case presents a profound question of federal law in a context that directly affects thousands of physicians every day. The plan has promulgated a method that essentially eliminates the physician's right to bill. The plan, however, refuses to actually release the method utilized to support its findings while failing to offer any justification for its secrecy. The plan's position and the district court's decision sustaining it, is contrary to basic due process principles. Stripped of the right to challenge the plan, physicians are seriously disadvantaged in their ability to protect their rights in a court of law.

This is the ideal case in which to take up the question whether a health plan may, without special circumstances, circumvent federal law. The facts perfectly illustrate the dangers that such action creates. Left unchanged, this case will establish a new precedent for ERISA plans. The need for openness, rather than misrepresentation, is accordingly at the apex in this case. A fundamental principle of Due Process under the Constitution is that one is entitled to know the terms of actions being enforced against him. "Living under a rule of law entails various suppositions, one of which is that [all persons] are entitled to be informed as to what the State commands or forbids." *Papachristou v. City of Jacksonville*, 405 U.S. 156, 162 (1972) *quoting Lanzetta v. New Jersey*, 306 U.S. 451, 453 (1939). As this Court has explained, the purpose of fair notice enables the ordinary citizen to conform. *City of Chicago v. Morales*, 527 U.S. 41, 58 (1999). Openness and transparency are the strongest temptations, the strongest incentive for maintaining responsibilities to all parties.

SUMMARY OF ARGUMENT

The Second Circuit's ruling in the instant case is consistent with a deviant pattern it has followed since the seminal and unambiguous ruling by this Court in *Firestone Tire and Rubber Co v. Bruch*, 489 U.S. 101, 109 S. Ct. 948 (1989). This Court held that ERISA is governed by the standards of trust law and the default standard of review of an ERISA plan administrator's decisions to deny benefits is "de novo." *Firestone*, 489 U.S. at 101. However, when the plan documents grant discretion to the plan fiduciary to make such decisions, then these decisions will be reviewed under an abuse of discretion standard. *Id.* at 102. When the

question of a conflict of interest on the part of the administrator is plausibly raised, the circuits are divided on how to carry out *Firestone's* directive that conflicts of interest "must be weighed as a 'factor in an abuse of discretion review.'" *Id.* at 115. There is no question that the district court, whose function was to limit the deference accorded respondent, failed to do so and failed to initiate a de novo review of the evidence presented by respondent in support of its position. The evidence presented by respondent showed that respondent's self-interest in recouping monies caused it to breach its fiduciary obligations to its beneficiaries and to petitioners, as assignees.

Four circuits, including the Second Circuit, require that a claimant demonstrate in advance that a conflict of interest has affected the decision of the fiduciary, and if the claimant cannot, the court gives no weight at all to the conflict – effectively, the claimant must demonstrate that the decision was unreasonable for the court to consider the conflict at all. *See, e.g., Whitney v. Empire Blue Cross and Blue Shield*, 106 F.3d 475, 476-477 (2d Cir. 1997); *Mers v. Marriott Intern. Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1020 (7th Cir. 1998); *Buttram v. Central States, Southeast and Southwest Areas Health and Welfare Fund*, 76 F.3d 896, 900 (8th Cir. 1996); *Jordan v. Northrop Grumman Corp. Welfare Benefit Plan*, 370 F.3d 869, 875-6 (9th Cir. 2004). Seven circuits do give some weight to conflicts of interest in determining whether the fiduciary abused its discretion, though they are split on exactly how to do so. *See, e.g., Pari-Fasano v. ITT Hartford Life and Acc. Ins. Co.*, 230 F.3d 415, 419 (1st Cir. 2000); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 378-9 (3d Cir. 2000); *Smith v. Continental Cas. Co.*,

369 F.3d 412, 417-8 (4th Cir. 2004). This Court has recently observed that this issue is unresolved, but declined to resolve it at that time as it was not necessary for the disposition of the case before it. *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 384 n.15, 122 S. Ct. 2151 (2002). Resolution of this issue is necessary for the disposition of this case.

The Second Circuit affirmed the District Court's decision dismissing petitioners' action and permitting respondent to retain all monies due to petitioners in order to recoup payments previously made to petitioners. The decision was granted solely on the basis of an incomplete administrative record presented by respondent. The issue of conflict of interest permeated the trial but was not given consideration by the trial court. Respondent's Fraud and Abuse Committee, which made the conclusion that appellants had been overpaid, was comprised entirely of employees of the Fund and operated with the singular intent to recoup monies from physicians participating under their plan. To that end, the committee targeted petitioners and 69 other physicians with whom it had a contractual relationship. The committee was selected, quartered, and paid by the plan, and worked out of offices provided by the plan. In short, the pedigree of this committee raises serious conflict of interest questions.

Armed with its own statistical data, its belief and interpretation of one of Dr Sewell's letters, which the District Court recognized to be not the only interpretation, and imbued with the power of the Fund's fiduciary authority, the committee eschewed the rules of fair play embodied in the governing ERISA regulations and failed to provide a complete administrative record or review documentation

affecting the claims in question before they were withheld, then failed to notify petitioners, in a manner designed to deny petitioners their rights of administrative reviews and appeal. Not only did the committee's composition fail to comply with the terms set forth in the written contract between the parties, but also, no attempt was made to foster an appearance of independence. The committee never subjected its methodologies to independent review and never afforded petitioners or any of the targeted physicians the opportunity to challenge their statistical model or the conclusions regarding the claims. In addition, recoupment was not limited to beneficiaries of claims on whose behalf the alleged overpayments were made, and there was no notification to the beneficiaries of overpayments made on their previously paid claims.

A conflicting interest has a tremendous impact on the evaluation of any fiduciary's actions. Yet, the District Court failed to recognize the prejudice heaped on the petitioners by this inherent conflict of interest. Such an oversight by the Court is incomprehensible. The Fraud and Abuse Committee's unilaterally constructed, imposed, and prosecuted statistical reviews ought to be scrutinized. The District Court recognized that the actions of the Fraud and Abuse Committee definitely limited the development of the administrative record on all claims submitted to respondent. The District Court recognized that, as assignees, petitioners did not receive proper denials of benefits as required by ERISA and were therefore denied the right to the administrative review process, but did not mandate such a review. The District Court's conclusion on these issues, therefore, that the plan administrator's actions were reasonable and not arbitrary and capricious

eviscerates well understood rules of fairness, and warrants review.

With regards to the concept of deference which underpins the application of the *Firestone* decision, it is illogical for the District Court to be compliant with that decision when the constitution and convention of Respondent's Fraud and Abuse Committee fall outside the boundaries of ERISA, the terms of the Physician Participating Agreement, and each of Respondent's Medical Provider Manual and Summary Plan Description. Equally, elevation of the actions of the Fraud and Abuse Committee is to adorn an illegal body with garments of propriety. In the premises, both the District Court and the Second Circuit must have misapplied their minds to the reality of being less deferential to the findings of the Fraud and Abuse Committee. Arguably, even if the Fraud and Abuse Committee acted as an advisor to any other properly constituted committee, then it is submitted that it must be accountable to the stakeholders of the Fund. Likewise, it must be accessible to the review and appeal mechanisms that govern the Fund and its beneficiaries.

There is no question that the recoupment of benefits from petitioners allowed by the District Court and the Second Circuit is a form of restitution which is not allowed under ERISA. Rather, the statute provides for other appropriate equitable relief. At a maximum, therefore, the deemed overpayments to petitioners must be viewed as giving rise to only an equitable claim.

ARGUMENT

I. REVIEW IS NECESSARY TO RESOLVE A CONFLICT CONCERNING THE MANNER IN WHICH CONFLICTS OF INTEREST SHOULD BE FACTORED INTO THE ABUSE OF DISCRETION REVIEW

A. The Second Circuit Joins Three Other Circuits In Failing to Follow This Court's Holding That Conflicts of Interest Must Be Weighed In Judicial Review of Fiduciary Decisions Under 29 U.S.C. 1132(a)(1)(B)

The Second Circuit is involved in a split over the appropriate manner for dealing with conflicts of interest, choosing to give no weight at all to this factor unless the claimant can show in advance that the conflict affected the reasonableness of the denial of benefits. In addition, the Second Circuit joins with most, but not all, of its fellow circuits in using the arbitrary and capricious standard in place of the abuse of discretion standard prescribed by this Court in *Firestone*. The proper manner for handling ERISA cases under an abuse of discretion review, on which the circuits are split, is an important matter that warrants this Court's review. Further, this Court held that ERISA is governed by the standards of trust law and conflict of interest issues must be weighed as a factor in this determination. *Id.* at 102. The circuits are significantly divided on how to implement this directive.

B. Continued Use By The Circuits Of The Arbitrary And Capricious Standard In The ERISA Context Goes Against This Court's Holding In *Firestone*

Prior to *Firestone*, all of the circuits employed an arbitrary and capricious standard for all reviews of ERISA benefits denials. *Firestone*, 489 U.S. at 102. In the wake of *Firestone*, they were forced to reconsider this position. Notwithstanding this Court's prescription of an abuse of discretion standard, eleven of the circuits have chosen to continue using the arbitrary and capricious standard when an ERISA fiduciary is given discretion. *See, e.g., Diaz v. Seafarers Intern. Union*, 13 F.3d 454, 358 (1st Cir. 1994); *O'Neil v. Ret. Plan for Salaried Employees of RKO Gen., Inc.*, 37 F.3d 55, 59 (2d Cir. 1994); *Nazay v. Miller*, 949 F.2d 1323, 1336 (3d Cir. 1991); *Penn v. Howe-Baker Eng'rs, Inc.*, 898 F.2d 1096, 1100 (5th Cir. 1990); *Davis By and Through Farmers Bank and Capital Trust Co. of Frankfort, Kentucky v. Kentucky Finance Cos. Retirement Plan*, 887 F.2d 689, 694 (6th Cir. 1989). The Fourth Circuit alone has abandoned the arbitrary and capricious standard in favor of the abuse of discretion standard. *See Booth v. Wal-Mart Stores, Inc. Assoc's Health and Welfare Plan*, 201 F.3d 335, 341 (4th Cir. 2000). Review is warranted to correct this split in the circuits and determine whether it is acceptable for the lower courts to continue its use of the arbitrary and capricious standard.

When a court reviews the decisions of an ERISA plan administrator for an abuse of discretion, that court is generally limited to an administrative record prepared by the plan administrator. *Miller v. United Welfare Fund*, 72 F.3d 1066, 1071 (2d Cir. 1995). However denial of discovery

beyond this administrative record is not due to any intrinsic meaning of the administrative record itself, rather, the court is limited to considering only what was before the plan administrator at the time the decision was made. *Id.*, at 1071. Nevertheless, the circuit courts have failed to make an exception to this rule for cases where the fiduciary fails to present the court with all of the documents that were before it when the decision was made. Since a proper abuse of discretion review cannot be performed without access to all the materials before the plan fiduciary at the time of its decision, the District Court should not be limited to the evidence presented by that fiduciary when the administrative record is incomplete. Review is warranted to correct this error in the circuits' ERISA jurisprudence.

II. REVIEW IS NECESSARY TO RESOLVE AN INHERENT CONFLICT OF INTEREST WHERE RESPONDENT USES A CLAIMS REVIEW SYSTEM THAT OPERATES CONTRARY TO ERISA'S CLAIMS PROCEDURES AND FAILS TO PROVIDE A FULL AND FAIR REVIEW

A. ERISA Mandates Full and Fair Review of Disputed Claims

ERISA mandates that: every employee benefit plan shall --(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim. 29 U.S.C. § 1133; see also 29 C.F.R. § 2560.503-1(g) (claimant is entitled to a "full and fair review of the claim and its denial"). Procedural fairness by plan fiduciaries is at the foundation of ERISA. *Weaver v. Phoenix Home Life Mut. Ins. Co.*, 990 F.2d 154, 157 (4th

Cir. 1993). The mandate that there be a full and fair review of the claim and its denial is, quite obviously, a meaningful and thorough substantive review of the evidence and the reasons the claim was denied. *See, Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 689 (7th Cir. 1992). The core requirement of a full and fair review is that the claimant be informed of the evidence the decision maker relied upon, that the claimant has an opportunity to address that evidence, and that the decision maker considers all of the evidence. Circuits have required substantial compliance with this condition. *Id.* at 689. The full and fair review requirements protect claimants and permit plan trustees to operate a plan "without the formality or limitations of adversarial proceeding..." *Grossmuller v. UAW*, 715 F.2d 853, 858 (3d Cir. 1983).

It is worth noting that the District Court ruled in its Memorandum Order dated August 3, 2005 that:

> ". . . the Fund's procedures place the onus on the Fund, and not plaintiffs, to request an internal review, and defendant has produced no evidence of any such request . . . . Finally, the internal appeals process is triggered by a written notice from the Plan administrator denying payment of benefits, and defendant has produced no evidence of such a written denial."

It is also worth noting that in its Motion for Reconsideration, respondent sought to convince the District Court that its letter dated March 11, 2004 was in fact a denial of the claims submitted by petitioners. The District Court correctly concluded in its Memorandum Order dated August 3, 2005, that the letter did not "remotely meet the requirements of an ERISA denial of benefits, let alone an adequate notice of appeal." By failing to mandate a formal

denial, the District Court's decision defeated ERISA's policy of promoting internal review and developing a comprehensive record.

B. District Court Acknowledges Plan's Failure to Follow Claims Procedures

A District Court's recognition of the Plan's failure to provide a formal denial, but not mandate it, defeats the ERISA policy of promoting internal administrative review as a prudent method of developing a comprehensive record. *Amato v. Bernard*, 618 F.2d 559, 567 (9th Cir. 1980); *see also* 29 C.FR. 2560.503-1(h). Petitioners never received a formal denial of the claims they submitted to respondent and thus no full and fair claim review. Though payment of all claims submitted by Petitioners were placed in a withholding status as of January 2004, the Plan failed to inform petitioners of that fact until March 11, 2004, never availed them of the internal review process and continued its action of withholding payments until the trial of this action which occurred in September 2005.

With the conscious intent to prevent the development of a full and complete record through the administrative process, organizations similar to the respondent's, through abuse of their administrative and fiduciary authority, deprive entitled parties access to a process that Circuits across the country and the US Congress deem essential.

C. Fund's Failure to Follow Review Procedures Is A Breach of Natural Justice

"When a plan administrator has failed to follow a procedural requirement of ERISA, the court may have to consider evidence outside the administrative record. For

example, if the administrator did not provide a full and fair hearing, as required by ERISA, 29 U.S.C. 1133(2), the court must be in a position to assess the effect of that failure and, before it can do so, must permit the participant to present additional evidence. We follow the Sixth Circuit in holding that, when an administrator has engaged in a procedural irregularity that has affected the administrative review, the district court should "reconsider [the denial of benefits] after [the plan participant has been given the opportunity to submit additional evidence." *Abatie v. Alta Health and Life Ins.* 485 F.3d 995, 959 (9th Cir. 2006) (*quoting Vanderklok v. Provident Life and Accident Ins. Co.*, 956 F.2d 610, 617 (6th Cir. 1992)).

III. REVIEW IS WARRANTED BECAUSE THE DISTRICT COURT CANNOT PERFORM THE ABUSE OF DISCRETION REVIEW REQUIRED BY THIS COURT IN *FIRESTONE* WHEN THE ERISA FIDUCIARY PRESENTS AN INCOMPLETE ADMINSTRATIVE RECORD TO THE COURT

A. District Court Ruled Additional Documentation Consistent With ERISA's Requirement For Full and Fair Review To Be Irrelevant

In the course of the trial, the Fund presented a vague description of the methodology employed in constructing the review system. Petitioners challenged the Fund's reasoning claiming the scheme was void due to its vagueness. The District Court heard testimony that the Fund had made its decision to withhold benefits before a review of documentation, yet concluded that documentary review during the trial was irrelevant. The District Court nonetheless

found the decision to be reasonable and not arbitrary and capricious. The District Court did not address petitioners' complaint as to whether the subsequent action by the Fund of withholding benefit payments of all claims submitted by petitioners for more than one and one-half years without notification of an adverse benefit determination was a valid act under ERISA's claims procedure.

B. The Reasonableness of the Fund's Decision Was Not Reached On The Record

The reasonableness of a de facto denial in the form of withholding payments based on review of claims by a unilaterally constructed statistical review process must be reviewed for a conflict of interest. The District Court recognized the Fund's actions as falling short of being an official denial. Yet, the district court did not review the Fund's actions for a conflict of interest.

In the case at bar, the reasonableness of the Plan's decision could not be said to have been reached as the record on the withheld claims were never developed and the Plan did not disclose its methodology used for the calculation of payments. The conclusion that it had made overpayments was solely on the basis of statistical comparisons, patterns and deviations, and not on the claims themselves. A major point of contention with the Plan's calculation of overpayment is that all the parties who comprised the fraud and abuse committee were under the influence of the Plan, with the singular objective of recovering payments it claimed it had overpaid.

The burden is on the Plan to build up and document all relevant information utilized to make a decision on a claim. *See, Booton v. Lockheed Medical Benefit Plan*, 110

F.3d 1461, 1464 (9th Cir. 1997). Included in that burden is a requirement that doctors or other medical experts that assess the claim be independent. *See, e.g., Booton*, 110 F.3d at 1465; *Monroe v. Pacific Telesis Group Comprehensive Disability Benefits Plan*, 971 F. Supp. 1310, 1315-16 (C.D. Cal. 1997) (granting plaintiff's motion for summary judgment upon finding the plan administrator had failed to consult independent experts and noting it was also evidence of bad faith)(*citing Sansevera v. E.I. Dupont de Nemours & Co.*, 859 F.Supp. 106, 112-13 (S.D.N.Y. 1994). No one can argue that the individuals who constructed the Plan's review system were not independent inasmuch as the individuals were employed by, and operated completely under, the Plan's sphere of influence. Further, Dr. Shmukler, the medical doctor who reviewed the medical records provided during the trial (none of which were records for the payment of claims which were withheld) was employed by the Fund as its medical director and was a member of the committee which made the decision to withhold payment. While Dr. Shmukler maintained during her direct testimony that petitioners did not use the correct CPT code for the medical services which were provided to patients, on cross-examination along AMA Guidelines, Dr. Shmukler conceded that the CPT codes as submitted were correct for the level of services provided. This, of course, is the universally accepted basis for determining the validity of an E&M CPT code upon review. Yet, the District Court in its decision approved the unilateral downcoding of CPT codes one level without the review of medical records. In fact, the District Court found testimony relating to the Plan's medical director's knowledge of CPT code selection criteria and the assessment of medical records presented as evidence to be irrelevant.

C. The District Court's Decision Is At Variance With The Decisions Of Other Circuits

It is submitted that the decision of the district court is at variance with the decisions of other circuits which have dealt with the issue and with the rationale of the Supreme Court. The Ninth Circuit, relying on the principles set forth in *Firestone* reconsidered its "approach to ERISA cases in which a plan administrator denies benefits and (1) the wording of the plan confers discretion on the plan administrator and (2) the plan administrator has a conflict of interest." *Abatie*, 485 F.3d at 959. The *Abatie* court noted that it had previously "held that an insurer that acts as both the plan administrator and the funding source for benefits operates under what may be termed a structural conflict of interest." *Id.* at 959 (citing *Tremain v. Bell Indus., Inc.*, 196 F.3d 970, 976 (9th Cir. 1999) (noting that a conflict of interest exists when an insurer both administers and funds an ERISA plan). The *Abatie* Court noted that

> "[o]n the one hand, such an administrator is responsible for administering the plan so that those who deserve benefits receive them. On the other hand, ***such an administrator has an incentive to pay as little in benefits as possible to plan participants because the less money the insurer pays out, the more money it retains in its own coffers***."

Id. At 965-66 (emphasis added) (citing *Doe v. Group Hosp. & Med. Servs.*, 3 F.3d 80, 86 (4th Cir. 1993) (noting that "to the extent that [the administrator] has discretion to avoid paying claims, it thereby promotes the potential for its own profit"); *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1561 (11th Cir. 1990) (similarly

noting that an administrator's role as a fiduciary lies in conflict with its role as a profit-making entity). This inherent conflict of interest, even if merely formal and unaccompanied by indicia of bad faith or self-dealing, should have some effect on judicial review.

In discussing the standard of review to be applied when the plan administrator fails to follow procedural requirements, the *Abatie* court stated the following:

> When an administrator engages in wholesale and flagrant violations of the procedural requirements of ERISA, and thus acts in utter disregard of the underlying purpose of the plan as well, we review de novo the administrator's decision to deny benefits. We do so because, under *Firestone*, a plan administrator's decision is entitled to deference only when the administrator exercises discretion that the plan grants as a matter of contract. 489 U.S. at 111, 109 S.Ct. 948. Firestone directs, consistent with trust law principles, that "a deferential standard of review [is] appropriate when a trustee exercises discretionary powers." *Id.* (emphasis added). ***Because an administrator cannot contract around the procedural requirements of ERISA, decisions taken in wholesale violation of ERISA procedures do not fall within an administrator's discretionary authority.***"

Id. at 971-72 (emphasis added)

The Fourth Circuit in *Ellis v. Metro. Life Ins. Co.*, noted that "a reviewing court should consider, to the extent relevant, (1) the scope of the discretion conferred; (2) the purpose of the plan provision in which the discretion is granted; (3) any external standard relevant to the exercise

of that discretion; (4) the administrator's motives; and (5) any conflict of interest under which the administrator operates in making its decision. 126 F.3d 228, 223 (4th Cir. 1997). The Fourth Circuit further noted that

> "[W]hen a fiduciary exercises discretion . . . where one interpretation will further the financial interests of the fiduciary, we will not act as deferentially as would otherwise be appropriate. Rather, we will review the merits of the interpretation to determine whether it is consistent with an exercise of discretion by a fiduciary acting free of the interests that conflict with those of the beneficiaries. In short, the fiduciary decision will be entitled to some deference, but this deference will be lessened to the degree necessary to neutralize any untoward influence resulting from the conflict."

Id. at 233.

There is no question that adverse benefits determinations save considerable sums that are returned to the fiduciary's corporate coffers and thus a decision like the one at bar which seeks to recoup monies from unwary physicians inherently implicates the hobgoblin of self-interest. Thus, the representation by any fiduciary that it is acting for the future stability of the fund should not be entertained and should be discouraged when the fiduciary suffers a conflict of interest. *See Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 142-43, 105 S.Ct. 3085, 3091, 87 L.Ed.2d 96 (1985) ("the avoidance of conflicts of interest" is among the primary statutory duties imposed by ERISA on fiduciaries); *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir. 1982), *cert. denied*, 459 U.S. 1069, 103 S.Ct. 488, 74

L.Ed.2d 631 (1982) (fiduciaries must "avoid placing themselves in a position where their acts [in their other roles] will prevent their functioning with the complete loyalty to participants demanded of them as [fiduciaries]").

IV. THE SECOND CIRCUIT'S APPROACH TO THE STANDARDS OF DEFERENCE TO BE ACCORDED FIDUCIARY ACTIONS

When determining whether there was an abuse of discretion when an ERISA fiduciary terminated plan benefits, the court must weigh a fiduciary's conflict of interest that is "plausibly raised" as a factor. *Firestone*, 489 U.S. at 950; *Pegram v. Herdich*, 530 U.S. 211, 219-20 (2000); *Rush*, 536 U.S. at 384 n15. Notwithstanding these holdings, the Second, Seventh, Eighth and Ninth Circuits have constructed their ERISA tests such that conflicts of interest will never be a factor unless the administrator's decision was already an abuse of discretion on its face. Review is necessary to correct these lines of cases.

In the Second Circuit, a conflict of interest is given no weight by the court unless the claimant has already independently shown that the conflict affected the reasonableness of the administrator's decision. *Sullivan v. LTV Aerospace & Def. Co.*, 82 F.3d 1251, 1259 (2d Cir. 1996). Under this standard, if the claimant cannot show that the decision was unreasonable, then the conflict of interest is effectively ignored. Thus, in order to have the Second Circuit consider the conflict, a claimant must essentially have already demonstrated that the fiduciary had abused its discretion. Accordingly, unless the Plan acting as ERISA fiduciary has been careless enough to allow some specific evidence of how they treated this particular claimant in a

biased fashion, the court will ignore the conflict. Among those circuits that have given weight to conflict of interest, there is still significant disagreement on how to account for this factor. This Court has noted the presence of an unresolved issue with regards to the proper method for accounting for conflicts of interest in the ERISA context. *Rush*, 536 at 384 n15. The seven circuits that have followed this Court's holding in *Firestone* and given weight to plausibly raised conflicts of interest have produced a variety of ways of dealing with these conflicts. The Tenth and Eleventh Circuits use a burden shifting approach to handle conflicts of interest. In both circuits, where there is a conflict of interest raised by the claimant, the burden shifts to the fiduciary to prove that the decision was not an abuse of discretion. *Fought v. UNUM Life Ins. Co. of America*, 357 F.3d 1173 1181-5 (10th Cir. 2004); *Brown*, 898 F.2d at 1566-7. In the Third and Fourth Circuits, the level of scrutiny is based on the seriousness of the conflict of interest, and "deference will be lessened to the degree necessary to neutralize any untoward influence resulting from the conflict." *Pinto*, 214 F.3d at 378-9; *Smith*, 369 F.3d at 417-8. In the First Circuit, "the possible existence of a conflict of interest would necessarily affect the court's determination of what was reasonable conduct by the insurer under the circumstances." *Pari-Fasano*, 230 F.3d at 419. Since the seven circuits that weigh conflicts of interest when plausibly raised have produced three distinct methods of dealing with those conflicts, review is warranted to unify the circuits.

In the Second Circuit, a decision fails the arbitrary and capricious standard if it is "without reason, unsupported by substantial evidence or erroneous as a matter of law."

Pagan v. NYNEX Pension Plan, 52 F.3d 438, 442 (2d Cir. 1995). A decision that fails any one of these prongs will therefore fail the arbitrary and capricious test but in practice no ERISA fiduciary will produce a record without some reason. It is unclear what fiduciary decision could possibly be erroneous as a matter of law. The only prong left to apply a true test of the fiduciary's decision is the substantial evidence prong. However, the Second Circuit's standards fail to follow this Court's guidance in that it fails to weigh conflicts of interest as a factor. Since the Second Circuit provides even more deference to plan fiduciaries than this Court has prescribed, review is warranted to correct this anomaly.

Review is warranted to ensure that ERISA beneficiaries and their assignees receive the review this Court has held they are entitled to, and to ensure that ERISA fiduciaries are honest with the court and present complete administrative records for judicial review.

V. RECOUPMENT OF MONIES GROUNDED IN RESTITUTION IS LEGAL IN NATURE

This Court has observed repeatedly that ERISA is a "'comprehensive and reticulated statute,' the product of a decade of congressional study of the Nation's private employee benefit system." *Mertens v. Hewitt Associates*, 508 U.S. 248, 251 (1993) (quoting *Nachman Corp. v. Pension Benefit Guaranty Corporation*, 446 U.S. 359, 361 (1980)). This Court has stated its reluctance "to tamper with [the] enforcement scheme embodied in the statute by extending remedies not specifically authorized by its text." *Massachusetts*, 473 U.S. at 147. Additionally, this Court has noted that ERISA's "'carefully crafted and detailed

enforcement scheme provides strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly.'" *Mertens*, supra, at 254 (quoting Russell, supra, at 146-147).

Under ERISA, Congress authorized "a participant or beneficiary" to bring a civil action "to enforce his rights under the terms of the plan," without reference to whether the relief sought is legal or equitable. 29 U.S.C. § 1132(a)(1)(B) (1994 ed.). But Congress did not extend the same authorization to fiduciaries. Rather, § 502(a)(3), by its terms, only allows for equitable relief. Recoupment of payment, being a form of restitution, is not permissible under ERISA.

It is undisputed that ERISA permits money awards only in very limited circumstances. 29 U.S.C. Section 1132(a)(3). The Second Circuit has held that the "only conceivable equitable claim" for cash money lies under the antique equitable remedy of restitution. *Strom v. Goldman, Sachs & Co.*, 202 F.3d 138, 144-45 (2d Cir. 1999) (citing *Geller v. County Line Auto Sales, Inc.*, 86 F.3d 18 (2d Cir. 1996)). Thus, in order to make out a claim for restitution, Respondent must show that Petitioners had unjustly received from it a benefit, such as a payment, see *Great-West Life & Annuity Ins. Co. v Knudson*, 534 U.S. 204, 213, 122 S.Ct. 708 (2002); *Geller*, 86 F.3d at 22. In the case at bar, the District Court found that Respondent had not made out a claim for unjust enrichment and dismissed this counterclaim. Having dismissed Respondent's counterclaim for unjust enrichment, it follows that a recoupment of monies grounded in restitution, and which is legal in nature, cannot lie. Recoupment of payment, being a form of restitution, is not permissible under ERISA as reflected in the records of the court below.

STATEMENT IN CONCLUSION

The methodology utilized by the Fund's Fraud and Abuse Committee in concluding the actions of the seventy (70) doctors, including petitioners was flawed and therefore inaccurate or questionable. As noted, the committee was composed of employees of the Fund. This resulted in an obvious conflict of interest whereby these individuals were determined to find fault with the claims submitted by petitioners, then apply coercive and intimidatory methods of recoupment in the form of withholding payments due. The committee operated with impunity and recouped benefits from all the claims submitted by Petitioners, not just claims from beneficiaries to whom it made alleged overpayments.

The case at bar is a perfect example of such abuse. During the course of the litigation and even upon the conclusion of the trial, the Plan continued its actions of withholding payments due appellants and repeatedly down-coded submitted claims without explanation. The withholding continued during the course of the subject litigation, even after the Fund had reached the amount of its alleged overpayment. In short, Respondent withheld over $300,000 for an alleged overpayment of $133,167. In addition, the Fund has used the district court's decision as authority to continue its downcoding of claims without review and in order to continue its recoupment of alleged overpayments.

The lower courts' rulings, based entirely upon general observations of patterns of billing that invoke a suspicion of "improper billing practices" as presented by defendants, and an interpretation of one of Dr. Sewell's letters, which

appears to confirm this suspicion, while acknowledging that this was not the only interpretation, and not on the record or lack thereof, that was developed on the denied claims; result not in a check of the potential abuses but actually empowers respondent and expands the possibility of abuse that may be inflicted on petitioners and other physicians in the pursuit of "cost reductions." The failure to issue notices of denial of benefits and to provide access to the appeals process and a full and fair review, while concomitantly recouping payments for alleged overpayments on the basis of a unilaterally constructed statistical review served to deny petitioners of the opportunity to resolve any discrepancies between their billing patterns and respondent's unstated requirements, to present complete documentary evidence pertinent to any denied claims in order to verify their validity, to challenge the Fund's methodology for the calculation of benefits for these claims, and to file for de novo trial after a full administrative record on the subject claims has been developed under Section 502(a)(1)(B) of the Act, was an abuse of fiduciary authority and the basis of plaintiff's lawsuit. These actions and omissions were not consistent with ERISA regulations or with the contract which also governed the actions of the parties. They did not follow established precedent and were unreasonable and prejudicial, causing significant harm to plaintiffs.

It is important to note that respondent targeted only those physicians with whom it had contractual relationships and who are least able statutorily to dispute any "billing differences" as a result of a vacuum created by the party drafting the agreement, i.e., respondent. Faced with the notion that the Fund does not require assignments of

benefits in order to pay physicians, a physician who fails to obtain valid assignments from patients have no recourse in either the federal or state courts for the egregious conduct of the Fund. As an ERISA governed health plan, respondent can craftily use its federal status to avoid defending an action in State court. Faced with the possibility of the state action being dismissed because of improper venue, and the federal action being dismissed because physicians are not one of the parties enumerated under ERISA with standing to bring an action, physicians have no remedy by which to contradict any findings. Consequently, the only option for physicians is to acquiesce to respondent's demands of overpayment. When this is combined with indefinite withholding of payment without administrative reviews and appeals, the Fund has an extremely powerful and coercive tool to force acquiescence to their demands.

CONCLUSION

The petition for a writ of certiorari should be granted, the judgment of the court of appeals should be vacated, and the case should be remanded for further consideration in light of this Court's decision in *Firestone*.

Respectfully submitted,

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APPENDIX

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UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

THIS SUMMARY ORDER WILL NOT BE PUBLISHED IN THE FEDERAL REPORTER AND MAY NOT BE CITED AS PRECEDENTIAL AUTHORITY TO THIS OR ANY OTHER COURT, BUT MAY BE CALLED TO THE ATTENTION OF THIS OR ANY OTHER COURT IN A SUBSEQUENT STAGE OF THIS CASE, IN A RELATED CASE, OR IN ANY CASE FOR PURPOSES OF COLLATERAL ESTOPPEL OR RES JUDICATA.

At a stated term of the United States Court of Appeals for the Second Circuit, held at the Thurgood Marshall United States Courthouse, Foley Square, in the City of New York, on the 14th day of June, two thousand and six.

No. 05-6096-cv

PRESENT:

HON. CHESTER J. STRAUB,
HON. SONIA SOTOMAYOR,
HON. PETER W. HALL,
Circuit Judges.

CLINTON SEWELL, M.D.,
CARICARE MEDICAL SERVICES, P.C.,

Plaintiffs-Counter-Defendants-Appellants,

v.

THE 1199 NATIONAL BENEFIT FUND FOR
HEALTH AND HUMAN SERVICES,

Defendant-Counterclaimant-Appellee.

Appearing for Appellants:	VIVIA L. JOSEPH, Cambria Heights, N.Y. (Deveraux Cannick, Aiello & Cannick, Maspeth, N.Y., *of counsel*).
Appearing for Appellee:	JENNIFER MIDDLETON, Levy Ratner, P.C., New York, N.Y. (Jeffrey G. Stein, General Counsel 1199 SEIU Funds, New York, N.Y., *on the brief*).

SUMMARY ORDER

Appeal from a final decision of the United States District Court for the Southern District of New York (Jed S. Rakoff, *Judge*).

AFTER ARGUMENT AND UPON DUE CONSIDERATION, IT IS ORDERED, ADJUDGED, AND DECREED that the judgment of the District Court is hereby **AFFIRMED.**

Plaintiffs-Counter-Defendants-Appellants Clinton Sewell, M.D. and Caricare Medical Services, P.C. ("Sewell") appeal from a decision of the United States District Court for the Southern District of New York (Jed S.Rakoff, *Judge*) awarding judgment after a bench trial to the Defendant-Counterclaimant-Appellee the 1199 National Benefit Fund for Health and Human Services ("the Fund"). Sewell brought this action under § 502 of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1132, seeking payment for medical services he provided that were withheld by the Fund. After a bench trial, the District Court found that the Fund acted reasonably in withholding these payments to recoup prior overpayments to Sewell because of his improper billing practices. On appeal, Sewell contends that the Fund acted arbitrarily and capriciously in its investigation of his billing practices. Further, the Fund, according to Sewell, acted arbitrarily and capriciously in the manner it chose to recover the alleged overpayments. As neither of these arguments has merit, we affirm the District Court's judgment.

I.

Although we assume familiarity with the facts and procedural history of this case, we will briefly review the events giving rise to this case. Sewell is a physician practicing medicine in New York through his company-Caricare Medical Services P.C. The Fund is a multi-employer trust fund established for benefits of members of a labor union. The Fund qualifies as an ERISA "employee welfare benefit plan." *See* 29 U.S.C. § 1002(1). The terms of the benefit plan are described in its Summary Plan Description (SPD). During the period relevant to this appeal, Sewell

provided medical care to members of the union who participated in the Fund.

In 2003, the Fund formed a committee to investigate possible fraud and abuse of its billing system by its medical providers (the "Committee"). The Committee was composed of doctors employed by the Fund and other employees with different areas of expertise, including health care analysis, claims processing, and management of the Fund. One of the Committee members, Ralph Ullman, performed a study of the billing practices of the medical providers to identify "upcoding." Upcoding is a practice whereby medical providers submit claims to the Fund for more expensive procedures or treatments than those the patients actually received. The Fund requires its medical providers to submit bills for payment using the American Medical Association's (AMA) procedure codes (the "codes"). Each code corresponds to a particular treatment and a dollar amount that the Fund has agreed to pay. The AMA provides descriptions of the treatments, and the medical provider is responsible for selecting the appropriate code. Upcoding occurs when the medical provider selects a higher or more expensive code than the one that accurately reflects the services provided.

Ullman's study analyzed office visit claims submitted by 800 medical providers for the Fund. The study compared each of the 800 providers' code usage to average benchmarks for each provider's type of practice. The study identified 70 doctors—including Sewell—whose code usage varied significantly from the norms. For example, Sewell billed 99.7% of his new patients at the highest billing code for an office visit as compared to comparable doctors who billed 30.2% at the highest code. Sewell also billed 88.7% of office visits by his established patients at the highest

code while other comparable doctors only coded 8.7% of their established patients' visits at this code.

Based on these findings, the Fund began a dialogue with Sewell regarding his coding practices. On December 5, 2003, Sewell wrote to the Fund and provided a description of his method or "protocol" for billing and coding. In his letter, Sewell described how he assigned each office visit a number of "units" based on the time spent with the patient and the complexity of the issues. Sewell valued each "unit" as five dollars. Sewell then selected the code that best approximated the cash value he had assigned the procedure. Instead of matching the treatment provided to the appropriate code, Sewell selected the code that matched the dollar value he wished to receive. As he explained in another letter to the Fund, "[t]he billing protocol that I use . . . allows me to accurately and with great consistency obtain a fair value for each patient encountered. The value is the dollar amount that is sought as compensation. . . . [The] code that provides a payment amount that is closest to this amount is the code that is submitted for reimbursement."

After conducting further investigation, the Fund determined that from 1999 to 2003 Sewell had overbilled the Fund approximately $200,000 due to upcoding. The Fund recouped this amount by withholding payment on new claims submitted by Sewell from approximately January 2004 through the middle of 2005. To determine the amount to be set off against Sewell's debt, the Fund "downcoded" the claims submitted by Sewell—i.e. substituted a lower, less expensive code for the procedure than the one selected by Sewell.

II.

ERISA section 502 provides that a "civil action may be brought by a participant or beneficiary to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). Although section 1132(a)(1)(B) grants only plan beneficiaries or participants standing to bring a civil action to recover plan benefits, we have recognized a narrow exception that grants healthcare providers standing provided that a beneficiary has assigned to the provider his claim in exchange for healthcare services. *Simon v. Gen. Elec. Co.*, 263 F.3d 176, 177-78 (2d Cir. 2001) (per curiam) (citing *I.V. Servs. of Am., Inc. v. Trustees of Am. Consulting Eng'rs Council Ins. Trust Fund*, 136 F.3d 114, 117 n.2 (2d Cir. 1998)). Here, Sewell alleged in his complaint that he was an assignee of benefits under the Plan and that he therefore had a claim under ERISA against the Fund. Although the Fund apparently argued below that Sewell is not an assignee of any actual benefits from any plan beneficiary and that he therefore lacks standing to sue under ERISA, the Fund did not advance this argument on appeal and has consequently waived it.[1] We, therefore, turn to consider the merits.

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[1] At the time relevant to this appeal, Sewell was a participating provider under the Plan. His relationship with the Fund was governed by a Physician Participation Agreement with the Fund and included a fee schedule for covered services. According to the SPD, participating providers like Sewell "accept the Fund's payment as payment in full" for covered services, and the Plan's participants or beneficiaries receive care for those services "at no cost." When a participant or beneficiary uses a non-participating provider, by contrast, he or she "can be billed whatever the doctor normally charges" and the participant will "have to pay any cost over the Fund's allowance" for the service provided.

(*Footnote continued on the following page*)

The parties agree that we must review the Fund's denial of benefits under an arbitrary and capricious standard because the benefit plan gives the administrator discretionary authority both to determine eligibility for benefits and to construe the terms of the plan. *See Pagan v. NYNEX Pension Plan*, 52 F.3d 438, 442 (2d Cir. 1995). Following a bench trial, we review a district court's findings of fact for clear error and its conclusions of law de novo. *See* Fed. R. Civ. P. 52(a); *Connors v. Conn. Gen. Life Ins. Co.*, 272 F.3d 127, 135 (2d Cir. 2001). Because the District Court's determination that the Fund's decisions were not arbitrary and capricious is a legal conclusion, we review that determination de novo. *Celardo v. GNY Auto. Dealers Health & Welfare Trust*, 318 F.3d 142, 145 (2d Cir. 2003).

In the latter circumstance, the patient either pays the bill and is reimbursed by the Fund or assigns his or her rights to benefits to the provider, who seeks payment directly from the Fund. Where the patient receives services from a participating provider, however, it is not clear that the patient has anything to assign because the patient is entitled only to healthcare at no cost, not reimbursement. If the participant or beneficiary has no right to payment to assign to the participating provider, it is doubtful that the "narrow exception" to ERISA's otherwise stringent standing requirement would apply. *Cf. Blue Cross of Cal. v. Anesthesia Care Assocs. Med. Group, Inc.*, 187 F.3d 1045, 1050 (9th Cir. 1999) ("We hold that the Providers' claims, which arise from the terms of their provider agreements and could not be asserted by their patient-assignors, are not claims for benefits under the terms of ERISA plans, and hence do not fall within § 502(a)(1)(B)."); *Pasack Valley Hosp., Inc. v. Local 464A UFCW Welfare Reimbursement Plan*, 388 F.3d 393, 400-02 (3d Cir. 2004) (noting that the hospital, which had contracted with a consultant that in turn had contracted with individual ERISA plans, did not have standing to sue under ERISA because no claims had been assigned to it and the hospital's claims were "predicated on a legal duty that is independent of ERISA").

The first issue on appeal is whether the Fund acted arbitrarily or capriciously in determining that Sewell had engaged in upcoding. Sewell argues that the District Court erred by ignoring the Fund's breaches of the Physician Participation Agreement between Sewell and the Fund (the "Agreement"). Sewell, however, is judicially estopped from claiming that the Fund breached the Agreement.

Judicial estoppel "prevents a party from prevailing in one phase of a case on an argument and then relying on a contradictory argument to prevail in another phase." *New Hampshire v. Maine*, 532 U.S. 742, 749 (2001) (internal quotation marks omitted). Judicial estoppel is invoked where (1) a party's later position is "clearly inconsistent" with its earlier position, and (2) the party has succeeded in persuading a court to accept its earlier position. *Id.* at 750; *see also Mitchell v. Washingtonville Cent. Sch. Dist.*, 190 F.3d 1, 6 (2d Cir .1999).

In his Memorandum in Support of Its Motion for Reconsideration of the District Court's June 22, 2005 order, Sewell disclaimed that the Agreement forms the basis of his complaint and urged the court to reconsider its ruling that the action involved a breach of the Agreement:

> [T]he contractual relationship between the parties is not the basis of Plaintiffs' lawsuit. Rather, the Complaint filed in this action shows that Plaintiffs are suing as assignees under [ERISA] seeking reimbursement of benefits assigned to Plaintiffs by Members who participate under Defendant's health care plan. Plaintiffs reference to the Agreement is made solely in an effort to highlight for the Court that clause in the written agreement whereby Defendant agreed to compensate Plaintiffs "for Covered Services rendered to Members, which have

> been authorized as necessary pursuant to the UR program, in accordance with the applicable Benefit Fund fee schedule." Further, Plaintiffs have made no allegation that Defendant has refused to compensate Plaintiffs according to the applicable Benefit Fund fee schedule. Thus, no breach of contract has been alleged by Plaintiffs as against Defendant.

(Pls.'s Mem. in Supp. Recons. at 4.) This position is clearly inconsistent with his current claims that the SPD "did not establish the relationship between the parties; the Agreement did" (Appellant Br. at 30) and that the Fund breached the Agreement in its investigation of his billing practices (Appellant Br. at 15-29).

The second element of judicial estoppel is also present; the District Court was persuaded to accept Sewell's argument that his claim did not involve a breach of the Agreement. The District Court revised its order denying the Fund's motion for summary judgment and removed the sentence stating that the basis of the complaint was the Fund's breach of the Agreement. *Sewell v. 1199 Nat'l Ben. Fund for Health & Human Servs.*, No. 04 Civ. 4474, 2005 WL 1863816, at *1 (S.D.N.Y. Aug. 4, 2005). Sewell may not now claim that the Fund breached its obligations under the Agreement.

Returning to the merits of the case, we conclude that Sewell has failed to show that the Fund acted unreasonably in determining that he over-billed for the services he provided. Under the terms of the Plan, the Fund had authority not only "[t]o decide all maters arising in connection with entitlement to benefits, the . . . amount . . . of benefits and the operation of the Plan," but also "[t]o make all factual determinations required to administer, apply, construe and interpret the Plan." We agree with the District Court that

the Fund's conclusion that Dr. Sewell engaged in a practice of improper upcoding is neither arbitrary nor capricious. *See Celardo*, 318 F.3d at 147 (deferring to ERISA plan's finding that the participant had acted illegally and was disqualified from receiving benefits).

Sewell's second argument is that the Fund acted arbitrarily and capriciously in its withholding of payments to him. Sewell also challenges the Fund's calculation of the amount credited against the overpayment, specifically the Fund's practice of downcoding. The District Court correctly held that the Fund did not act arbitrarily or capriciously either by withholding future payments to Sewell or in its calculation of the amount to be set off against the overpayment. The SPD permits the Fund to withhold benefits where beneficiaries "[d]o not repay the Fund for benefits that [they] were not entitled to receive."[2] Indeed, the Fund has a fiduciary duty to "ensure that [the] plan receives all funds to which it is entitled." *Cent. States, Se. & Sw. Areas Pension Fund v. Cent. Transp., Inc.*, 472 U.S. 559, 571 (1985). The Fund, like any trustee, cannot pay a beneficiary more than the trust instrument authorizes and is entitled to recover any excess payment. *See Hoffa v. Fitzsimmons*, 673 F.2d 1345, 1354 (D.C. Cir. 1982); *see also* Restatement (Second) of Trusts § 254 (1959).

On the basis of his incorrect billing, the Fund overpaid Sewell for his services. Upon learning of the overpayments to Sewell, the Fund had both the duty and the authority to recoup the overpayments. Moreover, the Fund's methodol-

[2] There is one additional issue presented by this case: the Fund withheld from Sewell payments due for services provided to patient Y in order to recoup overpayments to Sewell for services previously provided to patient X. We see no bar to this kind of offset so long as actual beneficiaries are not thereby denied benefits for which they are otherwise eligible under the Plan.

ogy for withholding—downcoding his incoming bills one level—was a fair approximation of the correct value of his services and a reasonable response to the inherent difficulties posed by a more individualized inquiry.

For the foregoing reasons, the judgment of the District Court is therefore **AFFIRMED**.

FOR THE COURT,
ROSEANN B. MACKECHNIE, CLERK

By: _____

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT
THURGOOD MARSHALL U.S. COURT HOUSE
40 FOLEY SQUARE
NEW YORK 10007

FILED OCT. 31, 2006

Roseann B. MacKechnie
CLERK

Date:

Docket Number:	05-6096-cv
Short Title:	Sewell v. The 1199 National Benefit Fund for Health and
DC Docket Number:	04-cv-4474
DC:	SDNY (NEW YORK CITY)
DC Judge:	Honorable Jed Rakoff

At a stated term of the United States Court of Appeals for the Second Circuit, held at the Daniel Patrick Moynihan Courthouse, 500 Pearl Street, in the City of New York, on the 31st day of October, two thousand six.

Sewell v. The 1199 National Benefit

ORDER

A petition for panel rehearing and a petition for rehearing en banc having been filed herein by the appellants Sewell, et al. Upon consideration by the panel that decided

the appeal, it is Ordered that said petition for rehearing is **DENIED**.

It is further noted that the petition for rehearing en banc has been transmitted to the judges for the court in regular active service and to any other judge that heard the appeal and that no such judge has requested that a vote be taken thereon.

For the Court,
Roseann B. MacKechnie, Clerk

By: [ILLEGIBLE] HELLER
Motion Staff Attorney

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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04 Civ. 4474 (JSR)

CLINTON SEWELL, M.D. and
CARICARE MEDICAL SERVICES, P.C.,

Plaintiffs,

—*v.*—

THE 1199 NATIONAL BENEFIT FUND FOR
HEALTH AND HUMAN SERVICES,

Defendant.

MEMORANDUM ORDER

JED S. RAKOFF, U.S.D.J.

By this lawsuit, plaintiffs Clinton Sewell, M.D. and Caricare Medical Services, P.C. claim that the defendant, The 1199 National Benefit Fund for Health and Human Services (the "Fund"), breached a contract between the parties entitled the Physician Participation Agreement (the "Agreement"), which was entered into on January 19, 1999. *See* Physician Participation Agreement, January 19, 1999, attached as Exhibit A to Plaintiffs' Motion for Summary Judgment. Under the Agreement, plaintiffs were to provide medical services to Fund participants (called

"Members") and be compensated in accordance with the Fund's schedule of allowances. *See id.* ¶ 5; Memorandum of Law in Support of Defendant/Cross-Plaintiff's Motion for Summary Judgment of Plaintiffs/Cross-Defendants' Claims ("Def. Mem.") at 2. Following a "utilization analysis" in November, 2003 that concluded that plaintiffs had overbilled the Fund by $220,356, *see* Affidavit of Ralph Ullman, January 21, 2005 ("Ullman Aff."), ¶¶ 5-9, defendant, between January and November, 2004, withheld payment of $205,955.12 in claims submitted by plaintiffs, *see id.* ¶¶ 10-11. Plaintiffs then brought this suit, alleging that these sums had been wrongly withheld and that they suffered other damages as well.

On October 16, 2004, the Court denied defendant's motion to dismiss for lack of standing, finding that plaintiffs were proper assignees of the Members of the Plan. *See* Order dated October 15, 2004. On November 4, 2004, defendant filed its Answer and Counterclaims ("A&C"), claiming that plaintiffs were liable to defendant for fraud, unjust enrichment, and breach of contract. *See* A&C ¶¶ 62-170. Following discovery, both sides moved for summary judgment. In addition, defendant raised two objections to the Court's jurisdiction. *See* Def. Mem. at 10-14.

With one exception, these motions lack merit. As to the jurisdictional objections, it is beyond question that the Court has subject matter jurisdiction over this action and that plaintiffs have standing to sue. As the Court already explained at length during oral argument on the motion to dismiss, *see* transcript, October 15, 2004, defendant is a multi-employer, self-administered benefit fund, as defined in ERISA, 29 U.S.C. § 1002, and the presence of a private contract does not erase the fact that ERISA governs. Under § 502(a)(1)(B) of ERISA, health plan participants and ben-

eficiaries are authorized to bring federal civil enforcement actions in order to recover plan benefits, 29 U.S.C. § 1132(a)(1)(B), and it is settled law in this Circuit that assignees of those participants and beneficiaries have standing to sue under ERISA to recover for medical expenses incurred. *See, e.g., Simon v. General Electric, Co.*, 263 F.3d 176, 178 (2d Cir. 2001). Moreover, defendant has produced no evidence to suggest that plaintiffs are not valid assignees of the participant Members of the Fund.

As for defendant's further argument that the Court lacks jurisdiction because plaintiffs failed to exhaust their administrative remedies in the form of the Fund's internal review and appeal process, the Fund's procedures place the onus on the Fund, and not plaintiffs, to request an internal review, and defendant has produced no evidence of any such request. Further, the document upon which defendant relies as mandating an internal review, namely, the "Summary Plan Description," clearly applies to the relationship between the Plan and the Plan's Members, and not to the relationship between plaintiffs and defendant. *See* Summary Plan Description, attached as Exhibit B to Plaintiffs' Motion for Summary Judgment. Finally, the internal appeals process is triggered by a written notice from the Plan administrator denying payment of benefits, and defendant has produced no evidence of such a written denial.

As to the parties' cross-motions for summary judgment on the substantive claims, genuine issues of material fact remain that preclude summary judgment on any claim except for defendant's counterclaim for unjust enrichment. Unjust enrichment is an equitable claim that, under New York law (which governs this claim here), will not lie

where the rights and relationships on which it is premised is governed by an express contract. *See, e.g., Clark-Fitzpatrick, Inc. v. Long Island Rail Road Co.*, 70 N.Y.2d 382, 388 (N.Y. 1987); *Elias v. Albanese*, 00 Civ. 2219, 2000 U.S. Dist. LEXIS 11929, at *13 (S.D.N.Y. Aug. 21, 2000). Here, it is undisputed that the Agreement fully governs the rights and relationships on which the unjust enrichment counterclaim is premised. Accordingly, that counterclaim must be dismissed.

In sum, the Court hereby grants plaintiffs' motion for summary judgment dismissing defendant's unjust enrichment counterclaim, and hereby denies the parties' summary judgment motions in all other respects. The parties are reminded that trial will commence promptly at 9 a.m. on September 6, 2005 in Courtroom 14-B, 500 Pearl Street, New York, NY.

SO ORDERED.

/s/ JED S. RAKOFF
JED S. RAKOFF, U.S.D.J.

Dated: New York, New York
June 22, 2005

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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04 Civ. 4474 (JSR)

CLINTON SEWELL, M.D. and
CARICARE MEDICAL SERVICES, P.C.,

Plaintiffs,

—v—

THE 1199 NATIONAL BENEFIT FUND FOR
HEALTH AND HUMAN SERVICES,

Defendant.

MEMORANDUM ORDER

JED S. RAKOFF, U.S.D.J.

Both sides move for reconsideration of the Court's Memorandum Order of June 22, 2005 that denied both parties' respective motions for summary judgment and dismissed defendant's unjust enrichment counterclaim. The motions are granted in part and denied in part.

First, the parties complain that the Court erred in referring to plaintiffs' claim as one for "breach of contract," rather than as one brought under ERISA § 502, 29 U.S.C. § 1132 to recover benefits that are allegedly due plaintiffs as assignees of participants and beneficiaries of defen-

dant's Plan. Although the Court's June 22, 2005 Memorandum Order does initially state that plaintiffs' allege that defendant "breached a contract between the parties," *see* Memorandum Order dated June 22, 2005 at 1, it is clear from a full reading of the Memorandum Order that what is meant is a breach of defendant's obligations under the Plan. Nevertheless, for the sake of clarity, the Court hereby amends the first sentence of the June 22, 2005 Memorandum Order to read as follows: "Plaintiffs Clinton Sewell, M.D. and Caricare Medical Services, P.C. bring this lawsuit against defendant, The 1199 National Benefit Fund for Health and Human Services (the "Fund"), to recover benefits they allege are due them as assignees of participants and beneficiaries of defendant's ERISA Plan. *See* ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B)."

Second, the Court agrees with defendant that plaintiffs, as assignees of participants and beneficiaries ("Members") of the Plan, stand in the shoes of these Members. Accordingly, the Court hereby strikes from page 3 of its June 22, 2005 Memorandum Order the two sentences that read "Further, the document upon which defendant relies as mandating an internal review, namely, the 'Summary Plan Description,' clearly applies to the relationship between the Plan and the Plan's Members, and not to the relationship between plaintiffs and defendant." *See* Summary Plan Description, attached as Exhibit B to Plaintiffs' Motion for Summary Judgment.

Third, this means the Court must reach the question (which it previously did not reach) of whether the defendant is entitled to summary judgment on the ground that plaintiffs failed to exhaust the internal administrative remedies that were available to Members. *See Kinstler v. First Reliance Standard Life Ins. Co.*, 181 F.3d 243, 249-

51 (2d Cir. 1999); *Kennedy v. Empire Blue Cross and Blue Shield*, 989 F.2d 588, 592-93 (2d Cir. 1993). Specifically, defendant contends that plaintiffs failed to take an internal appeal from defendant's denial of their claims. However, the letter that defendant argues constituted the denials of claims (and thereby triggered a 60-day period in which plaintiffs had to seek administrative appeal in order to preserve their standing to bring this suit) it simply notifies plaintiffs that defendant is "withholding" payments "pending resolution" of a "continued review of [plaintiffs'] billing patterns and practices." Letter of Ruth Antoniades, March 11, 2004, attached as Ex. D to Plaintiffs' Motion for Summary Judgment. This does not remotely meet the requirements of an ERISA denial of benefits, let alone an adequate notice of appeal. *See* 29 C.F.R. §§ 2560.503-1(g)(1)(i), -(iv);[1] *see also Burke v. Kodak Retirement Income Plan*, 336 F.3d 103, 107 (2d Cir. 2003) ("A written notice of denial [under ERISA] must be comprehensible and provide the claimant with the information necessary to

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[1] 29 C.F.R. § 2560.503-1(g)(1) states in pertinent part:

> The notification [of benefit determination] shall set forth, in a manner calculated to be understood by the claimant--
>
> (i) The specific reason or reasons for the adverse determination;
>
> (ii) Reference to the specific plan provisions on which the determination is based;
>
> (iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
>
> (iv) A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review; . .

perfect her claim, including the time limits applicable to administrative review. A notice that fails to substantially comply with these requirements does not trigger a time bar contained within the plan.").[2] Put another way, defendant, having simply stalled its resolution of plaintiffs' claims, has no basis to complain that plaintiffs have filed the instant suit.

The Court has considered the parties' other arguments for reconsideration and finds them without merit. Accordingly, the Court hereby reconfirms its denials of both parties' motions for summary judgment.

SO ORDERED.

/s/ JED S. RAKOFF
JED S. RAKOFF, U.S.D.J.

Dated: New York, New York
August 3, 2005

[2] While the Plan treats a failure of the defendant to issue a notice of denial or notice of extension within 90 days of the filing of a claim as a *de facto* denial, such a provision cannot override the statutory requirements for a proper notice as set forth in 29 C.F.R. § 2560.503-1(g)(1).

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---

04 Civ. 4474 (JSR)

CLINTON SEWELL, M.D. and
CARICARE MEDICAL SERVICES, P.C.,

Plaintiffs,

—v—

THE 1199 NATIONAL BENEFIT FUND FOR
HEALTH AND HUMAN SERVICES,

Defendant.

ORDER

JED S. RAKOFF, U.S.D.J.

Confirming this Court's oral ruling following a bench trial, *see* corrected transcript of proceedings of September 15, 2005, the Court finds that plaintiffs have failed to prove their case, and, accordingly, the complaint is dismissed with prejudice. Clerk to enter judgment.

SO ORDERED.

/s/ JED S. RAKOFF
JED S. RAKOFF, U.S.D.J.

Dated: New York, New York
October 11, 2005

PHYSICIAN PARTICIPATION AGREEMENT

Caricare Medical Services, P.C.
Clinton J. Sewell, M.D.

This Agreement is entered into as of the _____ day of 1998 (the "Effective Date") between 1199 National Benefit Fund for Health and Human Service Employees (the "Benefit Fund") and Clinton J. Sewell, M.D. *("Physician").*

WHEREAS, the Benefit Fund administers a health benefit plan, as described in the Summary Plan Description, attached hereto as Attachment A (the "Plan"), and offers the Plan to eligible members and their dependents;

WHEREAS, the Benefit Fund and Physician desire that Physician participate, in the Fund Provider Network and provide certain health care services to enrollees under the Plan and their eligible dependents ("Members");

NOW, THEREFORE, in consideration of the mutual covenants and agreements hereinafter contained, the parties agree as follows:

1. Covered services: *Physician agrees to provide those services (the "Covered Services") that are set forth in the Plan on pages 44-45 to Members to the extent of Physician's training, availability and resources, pursuant to the terms of this Agreement.*

2. Standard of Core/Non-Discrimination: *In providing the Covered Services, Physician shall observe the standards of care, skill and diligence that are applicable to the Covered Services in the community in which such Covered Services are rendered. Physician agrees that it*

shall not: (i) discriminate against any Member due to such person's status as a Member or on the basis of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age or health status; or (ii) make services more readily available to non-Members than to Members.

3. Good Standing: *Physician represents and certifies that he/she has and shall maintain in force at all times while this Agreement is in effect: all applicable licenses, permits and certifications required for the performance of his/her obligations hereunder. Physician shall immediately notify the Benefit Fund of any limitation, suspension or termination of any such licenses, permits or certifications. In addition, Physician certifies that the Principles of Medical Ethics as adopted or amended by the American Medical Association shall govern his/her professional conduct. Specifically, and in addition, Physician pledges that he/she will not receive from or pay to another physician any part of a fee received for professional services, in violation of any applicable law.*

4. Compliance with Plan and Medical Provider Manual: *Physician agrees to provide Covered Services in accordance with the Plan and to use his/her best efforts to comply with the policies and procedures set forth in the Medical Provider Manual, including the utilization review program contained therein (the "UR Program"). The Benefit Fund may amend the Plan and the Medical Provider Manual from time to time and shall provide Physician with prior written notice of any such amendments in accordance with Section 24 below.*

5. Compensation: *The Benefit Fund shall compensate Physician for Covered Services rendered to Members, which have been authorized as necessary pursuant to the*

UR Program, in accordance with the applicable Benefit Fund fee schedule, as promulgated and revised by the Trustees of the Benefit Fund (the "Fee Schedule"). Additional information on the Fee Schedule may be obtained by contacting the Director of Medical Benefits at (212) 465-4550.

The Benefit Fund shall use its best efforts to pay Clean Claims within 30 days of receipt. Clean Claims are fully completed claims submitted via electronic ENVOY NEIC Clearinghouse or HCFA 1500. The Benefit Fund shall use its best efforts to inform Physician of claims denied in full or in part or claims for which additional information is needed. The Benefit Fund shall use its best efforts to pay Clean Claims for which additional information is requested, within 30 days of receipt of all required information.

6. Hold Harmless: *Except as otherwise set forth in Section 6.1 below, Physician agrees to look solely to the Benefit Fund for payment of all claims for Covered Services. In no event, including but not limited to non-payment by the Benefit Fund or other breach of this Agreement, shall Physician bill, charge,collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any Member or person acting on the Member's behalf for services provided pursuant to this Agreement. This provision shall: (i) survive any termination of this Agreement, in which case the Benefit Fund shall compensate Physician for covered services performed in accordance with this Agreement and the Medical Provider Manual while this Agreement was in effect; (ii) apply to any course of treatment in progress at the time of termination; and (iii) supersede any oral or written contrary agreement now existing or hereafter made*

by and between Physician and a Member or person acting on a Member's behalf with respect to the subject matter hereof. Compensation by the Benefit Fund will be made in accordance with the Fee Schedule in effect prior to the termination of the Agreement.

6.1 Physician shall have the right to seek payment directly from: (i) a Member for services which are not Covered Services provided Physician has first notified the Member in writing that the service is not a Covered Service under the Plan and the Member, or person acting on the Member's behalf, consents in writing to have the service performed and (ii) a Member for any deductibles or coinsurance amounts that are the responsibility of the Member if, at any time during the term of this Agreement, such responsibilities are incorporated into the Plan.

7. Submission of Claims: *Physician shall submit claims for payment through the ENVOY NEIC Clearinghouse, HCFA 1500, or other comparable form acceptable to the Benefit Fund as described in the Medical Provider Manual. Claims shall be submitted within ninety (90) days from the date of service or discharge, as applicable, or within ninety (90) days from the date upon which it is established that the Benefit Fund is liable for payment, in accordance with the coordination of benefits rules and other procedures outlined in the Medical Provider Manual. Physician agrees that the Benefit Fund shall have the right to refuse payment for Covered Services provided by Physician if a claim for payment for such Covered Services is not submitted within such time frame, unless extraordinary circumstances exist.*

8. Maintenance and Retention of Member Medical Records; Financial and Administrative Records: *Physi-*

cian shall maintain Member medical records, and related financial and administrative records, that are accurate, complete, up-to-date, organized and otherwise in conformance with federal and state laws, accreditation requirements and good industry practice, so as to permit effective patient care, quality review, and administration of the Plan. Such records shall be retained by the Physician for at least the minimum periods of time required by such laws, requirements and practices.

9. Confidentiality of Member Medical Records: *Physician shall comply with all applicable laws, regulations, professional standards and Plan policies regarding the confidential treatment of Member medical information.*

10. Confidentiality of Proprietary Information: *The Benefit Fund and Physician acknowledge that in connection with their performance under this Agreement, each may have access to proprietary non-public information concerning the other's business and operations ("Confidential Information"). The Benefit Fund and Physician agree that neither party will utilize or disclose to any third party the other party's Confidential Information for any purpose other than the performance of this Agreement, except as required by law or expressly authorized by the other party. The Benefit Fund and Physician acknowledge that the financial terms and conditions underlying this Agreement constitute Confidential Information.*

11. Access to Member Medical Records; Financial and Administrative Records: *Upon prior written notice and during normal business hours, and subject to Section 9 above, Physician shall make available to the Benefit Fund for inspection and copying, at no costs to the Benefit Fund and upon prior written notice and during nor-*

mal business hours, all Member medical information, as well as all financial and administrative data pertaining to this Agreement, as may be required by the Benefit Fund for purposes of administering the Plan and monitoring Physician's performance under this Agreement. The Benefit Fund warrants to Physician that Members have agreed to release of their medical and administrative records to the Benefit Fund and Physician agrees that the Benefit Fund will not be required to obtain additional releases from such Members before inspecting, reviewing or copying such records.

12. Insurance: *Throughout the term of this Agreement, Physician shall maintain appropriate general liability insurance, professional liability, and other insurance of the types and in amounts customarily carried, and as shall be necessary, to insure Physician and his/her agents and employees against any claim or claims for damages arising from the performance or non-performance of services by Physician and his/her agents and employees in connection with this Agreement. The amounts and extent of such insurance coverage shall be subject to the approval of the Benefit Fund and, upon request, Physician shall furnish the Benefit Fund with appropriate evidence of such coverage. Physician further agrees to give the Benefit Fund 30 days prior written notice of any termination, reduction or modification of any such insurance policy. The Benefit Fund shall maintain any insurance policies or programs of self-insurance that are required of it by law.*

11. Term/Termination: *Either party of the Agreement may terminate this Agreement at any time upon sixty (60) days written notice to the other party. In addition; the*

Benefit Fund may immediately terminate this agreement as follows:

13.1 For conduct by the Physician that may reasonably be deemed to pose an immediate threat to the health, welfare or safety of Members;

13.2 Upon the loss or suspension of any licenses, certifications, or permits needed by the Physician to operate lawfully under state and federal law in accordance with the other requirements of this Agreement.

14. Post-Termination Obligations: *In the event that this Agreement is terminated for any reason other than pursuant to Sections 13.1 or 13.2 above, Physician shall continue a Member's course of treatment that began prior to such termination until the sooner of: (i) sixty (60) days from the effective date of termination; (ii) the date upon which the Benefit Fund transfers the Member to the care of another appropriate provider for the receipt of Covered Services; or (ii) the termination of the course of treatment. The Benefit Fund shall compensate Physician for such Covered Services in accordance with the then-current Fee Schedule.*

15. Indemnification: *Except as hereinafter provided in this Section 15 and Section 17, neither party hereto shall be liable to the other party, its agent or employees for any costs or expenses (including but not limited to attorneys fees, judgments, settlements, awards, or fines) associated with any claim, legal action, dispute resolution or administrative or regulatory proceeding arising out of or related to the actions or omissions of such other party, or such other party's employees or agents, under this Agreement. If suit is brought against the Benefit Fund alleging*

damages arising from allegedly negligent medical services Physician has provided, Physician will indemnify and defend the Benefit Fund against the suit.

16. Marketing Materials: *Physician agrees to permit the use of his/her name, address, telephone number, and a description of available Covered Services in Plan documents and provider directories. The Benefit Fund agrees to permit the use of its name and other identifying information by Physician in listings of those health care plans in which Physician is a participating physician. Each party shall obtain prior written approval from the other party before using the other party's name in any other promotional, advertising or public relations materials.*

17. Responsibility for Medical Decisions: *Physician acknowledges that the Benefit Fund does not and cannot practice medicine. Physician shall be solely and exclusively in control of all aspects of the practice of medicine and the delivery of health care services pursuant to this Agreement. Nothing contained herein shall be construed to relieve Physician of his/her responsibility to exercise his/her independent professional judgment with respect to the care and treatment of a Member.*

18. Independent Contractors: *Physician and the Benefit Fund are separate and independent legal entities. Nothing in this Agreement shall be construed to create a relationship of employer and employee, principal and agent, partnership, joint venture, or any relationship other than that of independent parties contracting with each other solely for the purpose of carrying out the provisions of this Agreement. Neither Physician nor the Benefit Fund has authority to enter into any contract, to assume any obligations, or to make any warranties or representations on behalf of the other concerning the*

duties, obligations or services of the other except as may be otherwise authorized in writing by the other.

19. Benefit Fund Trustees and Employees: *It is understood and agreed that the obligations of the Benefit Fund hereunder are not the personal obligations of the individual trustees and employees of the Benefit Fund and that no past, present or future trustee or employee of the Benefit Fund shall have any personal liability hereunder.*

20. Assignment and Delegation: *This Agreement shall be assigned nor may any rights or duties hereunder be delegated by either party to a third party without the prior written consent of the other party.*

21. Choice of Law: *This Agreement shall be governed by and construed in accordance with the laws of the State of New York. All claims or controversies relating to this Agreement shall be brought in state court in New York County or in a federal district court sitting therein.*

22. Notices: *All notices required or permitted to be given pursuant to this Agreement shall be deemed given if sent by certified mail, return receipt requested, postage prepaid, or by personal delivery or confirmed telecopy, to the following addresses:*

The Benefit Fund:	*Physician:*
Executive Director	*CLINTON J. SEWELL, M.D.*
310 West 43rd Street	*230-11 LINDEN BLVD.*
New York, NY 10036	*CAMBRIA HEIGHTS*
(212) 307-7500	*NEW YORK, 11411*

Either party at any time may change its address for notification purposes by mailing a notice as required hereinabove stating the change and setting forth the new address.

23. Severability: *If any part, term or provision of this Agreement is declared or found to be illegal, unenforceable or void, then both parties shall be relieved of all obligations arising under such provisions but the remainder of this Agreement shall not be affected by such declaration or finding and each provision not so affected shall be construed and enforced as if the Agreement did not contain the particular part, term or provision held to be illegal, unenforceable or void.*

24. Amendment: *The Benefit Fund, at its discretion, may amend the Agreement, Medical Provider Manual or Fee Schedule at any time upon thirty (30) days prior written notice to Physician. If the amendment is unacceptable to Physician, Physician may terminate the Agreement upon prior written notice to the Benefit Fund provided such notice is provided within the thirty (30) days notice period. Subject to Section 13 above, the effective date of termination shall be thirty days following receipt of Physician's notice. If Physician does not object to the amendment within the thirty (30) days notice period, such amendment shall be implemented and this Agreement shall remain in effect.*

25. Entire Agreement: *This Agreement, including any attachments or documents referred to herein, contains all the terms and conditions between the Benefit Fund and Physician and supersedes all other agreements, oral or otherwise.*

IN WITNESS WHEREOF, the Benefit Fund and Physician have entered into this Agreement as of the Effective Date.

1199 National Benefit Fund	*Physician's Signature*
By: /s/ Frank N. Carti	*By: /s/ Clinton J. Sewell*
Name: Frank N. Carti	*Name: Clinton J. Sewell, MD*
Title: Network Development & Contracts	*Title: MD - [Illegible]*
Date: 9/21/00	*Date: 2/19/99*

A 28pgs 268 (2)

No. 06-1053

IN THE

United States Supreme Court

CLINTON SEWELL, M.D.
CARICARE MEDICAL SERVICES, P.C.,

Petitioners,

v.

THE 1199 NATIONAL BENEFIT FUND FOR
HEALTH AND HUMAN SERVICES,

Respondent

On Writ of Certiorari to the
United States Supreme Court

PETITION FOR REHEARING

DEVERAUX L. CANNICK, ESQ.
AIELLO & CANNICK
Counsel of Record
69-06 Grand Avenue
Maspeth, New York 11378
718-977-4132

REASON FOR GRANTING A REHEARING OF WRIT

This case concerns the rights of physicians to sue as ERISA assignees in defense of their right to bill an ERISA plan and is of national importance inasmuch as there now exists a whirlwind type of overpayment recoupment crisis by plans like Appellee which withholds subsequent claim payments amounting to millions of dollars because federal and state agencies have turned a deaf ear to a healthcare provider's cry for justice due to a jurisdiction issue, while state government decline to intervene because of ERISA preemption and while federal government refuse to investigate because of alleged provider network contract agreement dispute. In the interim, healthcare providers receive no payments or little payments for already approved claims as a result of "overpayment" recoupment by the payers. This is an injustice which warrants the highest Court's review of this case.

The decisions of both the District Court and the Second Circuit affects over 800,000 physicians who provide medical services to members of ERISA-based health plans. Despite the presence of a blatant conflict of interest, the decisions of both the District Court and the Second Circuit have granted to Appellee and other health plans the authority to bypass ERISA's Claims Procedure by using mathematical analyses to form the sole basis to determine the validity of the medical claims for services provided by the health care providers.

ERRORS OF THE COURT OF APPEALS

The Court of Appeals makes certain assertions and misstatements in its decision which warrants a review of this

case by this Honorable Court. The Second Circuit ruling was based upon conclusions that reflect a misreading of the facts of this case.

1. Sewell was an Assignee with full ERISA rights. In its decision, the Second Circuit stated the following:

> At the time relevant to this appeal, Sewell was a participating provider under the Plan. His relationship with the Fund was governed by a Physician Participation Agreement with the Fund and included a fee schedule for covered services. According to the SPD, participating providers like Sewell "accept the Fund's payment as payment in full" for covered services, and the Plan's participants or beneficiaries receive care for those services "at no cost." When a participant or beneficiary uses a non-participating provider, by contrast, he or she "can be billed whatever the doctor normally charges" and the participant will "have to pay any cost over the Fund's allowance" for the service provided.

Pet. for Cert. A 6a n.1. Appellants do not dispute that Dr. Sewell agreed to "accept the Fund's payment as payment in full" for covered services. In fact, Dr. Sewell did accept the Fund's payment as payment in full. There is nothing in the record that Dr. Sewell filed appeals challenging the amount which he received from Appellee and there is nothing in the record that Dr. Sewell billed the members for any cost over the Fund's allowance. Finally, Dr. Sewell did not bring this action to challenge the payment which he received from the Appellee, which was far less that the charge for his services as set forth on the claim forms submitted to Appellee, but rather this case was brought to recover monies which had been placed in a withholding status, while there was no review pursuant to ERISA's Claims Procedure.

The Second Circuit's ruling is contradicted by Appellee's own Summary Plan Description which provides:

> A claim form needs to be filled out and sent to the Fund so that your doctor or health care provider can be paid . . .

(A-2a)

> If you want the Fund to reimburse your provider, you must sign the Assignment of Benefits statement on your claim form. . . .
>
> Note: The assignment feature of the Fund is only for payment of your benefits to providers . . . .

(A-4a)

From a reading of the Second Circuit's decision, it is clear that the Court has created a loophole for Appellee by suggesting that assignments were not permitted for Appellants, as participating providers.[1] The problem here is Appellee made no distinction in its Summary Plan Description between assignments to participating versus nonparticipating providers. Dr. Sewell fully followed the directives set forth in Appellee's Summary Plan Description. The fact that Appellee did not expect Appellants to obtain assignment from patients does not void the validity of the assignment forms. Further, the claim form[2] used by providers, both par-

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[1] This position is contradicted in the Medicare Claims Processing Manual, Chapter 26, in that the Form HCFA 1500 now known as Form CMS-1500, the basic form prescribed for claims from physicians and adopted by the American Medical Association (AMA Council on Medical Services, states that the patient's signature authorizes "payment of benefits to provider of services when the provider of service accepts assignment of the claim." *Medicare Claims Processing Manual, Chapter 26, Completing and Processing Form CMS-1500 Data Set.*

[2] *See Medicare Claims Processing Manual, Chapter 26, Completing and Processing Form CMS-1500 Data Set.*

ticipating and nonparticipating, is a mandatory form filed with the health plan by the provider in order to receive payment. There is no distinguishing feature for participating versus nonparticipating providers. There is also no language in Appellee's SPD which waives the filing of this claim form because the physician is a participating providers under Appellee's health care plan.

2. The Court of Appeals statement, "The Fund requires its medical providers to submit bills for payment using the American Medical Association's (AMA) procedure codes (the 'codes')" (Pet. for Cert. A-4a). The first part of the statement which follows, reads, "Each code corresponds to a particular treatment . . ." (Pet. for Cert. A-4a) is consistent with the intent of the AMA for the use of these codes as outlined in its published guidelines for CPT code selection—1995 Documentation Guidelines for Evaluation and Management Services. The second part of the statement, which reads ". . . and a dollar amount that the Fund has agreed to pay" (Pet. for Cert. A-4a) is a monetary assignment that the Fund has applied to these codes by criteria that were never agreed upon by the parties nor the AMA, and are yet unknown to Sewell.

In the usual course of his business, Sewell established a system of monetary assignment to CPT codes which utilizes the AMA selection criteria generated from the patient encounter in conjunction with the Medicare fee schedule to derive an amount to be charged for patient encounters. The code selection was verified upon medical record review by the testimony of the Fund's Medical Director. Comparison of the amounts charged by Appellant with the Fund's fee schedule shows that the Fund did not accept Appellant's fee as set forth on the claim form but paid a lower fee that did not exceed Appellee's fee schedule. Yet, the Fund continues to view the code selection used for the

patient encounter as "improper billing practices" and upcoding,[3] and have summarily downcoded the code selection and recouped monies without the inconvenience of verification by document reviews or claim denial notification and appeals as required by the ERISA statutes, but nevertheless justifiable on the basis of discretionary fiduciary authority. Implications from the use of these codes as the AMA intended and their use as billing codes as the Fund requires, presents a conflict, which the Fund circumvents by avoiding documentary review of the denied claims on the basis of fiduciary authority. CPT codes and billing codes are not equivalent and are not interchangeable, and the actions of the Fund's committee therefore warrants review and should not be accorded the customary deference allowed ERISA plan administrators. The Fund's recoupment activities on the basis of self-determined statistical deviations without documentary review establishes a previously unstated condition that the use of certain more expensive codes beyond an unspecified frequency implies upcoding, and will result in recoupment action in the form of downcoding of future claims without regard to whether AMA code selection criteria were satisfied by the selection of this code.

3. The Court of Appeals' assertion that because the benefit plan gives the administrator discretionary authority, "The parties agree" that the "Fund's denial of benefits" should be reviewed under an "arbitrary and capricious standard," is untrue. *See* Pet. for Cert. A-7a. There was never such an agreement. By way of coincidence both parties chose the same standard of review but for diametrically opposite reasons. Sewell's supplication to the court was to seek a meas-

[3] It is the result of this incorrect view that the Court of Appeals felt that Sewell used "more expensive codes than those that accurately reflect the services provided". Pet. for Cert. A-4a.

ure of relief from the action by the Fund of summary recoupment of monies on the basis of its own unchallenged statistical reviews and suspicions of ongoing improper billing practices only, and that as an ERISA sponsored plan the Fund had an obligation to initiate the review and appeals process that is mandated by ERISA when claims for benefits are denied, which would then permit Sewell to present in his own defense, a complete record for review by the Fund. Sewell contended that these actions were statutorily unsupported and prejudicial, and therefore arbitrary and capricious. It was the Fund in its defense that stated that its actions were supported by its discretionary authority to construe the terms of the Plan subject to its own interpretations and objectives. The Court of Appeals made no mention of Sewell's argument that his rights as an ERISA assignee were denied.

4. The Court of Appeals raised the issue that Participating Providers provide service "at no cost" to the beneficiary, as outlined in the Plan's Summary Plan Description, because the beneficiary does not file a claim and is not required to give assignment for the provider to be paid. This raises the question as to the source of monies that pay participating providers. Are they members' benefits? If so, they are subject to ERISA regulations and claims procedures. Additionally, Sewell obtained valid assignments making his claims payable from members' benefits and subject to the ERISA claims procedures.

CONFLICTS AMONG THE CIRCUITS WITH SUPREME COURT *FIRESTONE* RULING

Because the Circuits are divided on the applicable standard of review where the fiduciary clearly operates under a conflict of interest, rehearing is appropriate to clarify the confusion that exists among the Circuits. Further, this peti-

tion presents an ideal opportunity for resolution of the correct standard of review when a fiduciary like the one at bar acts pursuant to a conflict of interest and its final decision is monetary based. The issue here is as significant as the damages issue raised in the *State Farm Mut. Auto Ins. Co. v Campbell*, 538 U.S. 408 (2003).

The degree of deference accorded by the Federal judiciary to ERISA Plan fiduciaries[4] in the circumvention of ERISA statutes in the disposition of assigned medical claims is being brought to the United States Supreme Court for the first time, and is of major importance to over 800,000 physicians in the United States.[5]

The question which Appellee asks this Court to consider is whether Appellants have established a "split in the circuits" which would warrant the granting of this writ of certiorari. The answer is clearly yes. The petition of certiorari reveals facts that detail repeated non-compliance by several circuits with this Court's order in *Firestone*. The review process employed by the Second Circuit stands in stark contrast to the procedure outlined and mandated by this Court in *Firestone*. The procedural history of petitioner's case, as well as the records of similar actions brought throughout the country reveal glaring "conflicts" which authorize the granting of the

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[4] ERISA § 404(a)(1)(A) imposes a duty upon fiduciaries by requiring that "a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries." 29 U.S.C. 1104(a)(1)(A)

[5] Almost all health insurance in the United States—except for Medicare—is provided through employer-sponsored plans and is subject to ERISA. *See* Loraine Schmall & Brenda Stephens, ERISA Preemption: *A Move Towards Defederalizing Claims for Patients' Rights*. 142 Brandeis L.J. 529, 538 (2004).

certiorari. *Title 28 U.S.C. 2106* confers broad powers on the Supreme Court to vacate any judgment lawfully before it for review and to remand the cause for such action as may be fair under the circumstances. *Lawrence v. Chater*, 516 U.S. 163, 166 (1996). Granting certiorari, vacating, and remanding this case is appropriate and fair because of the likelihood that doing so will prevent the onslaught of recoupment that has been heaped upon the medical community. Finally, the decision below perpetuates a manifest injustice that the district court and the Court of Appeals have proven themselves unwilling to address. Under the precedent set by the Second Circuit, many,—if not most—of the physicians will find themselves locked out of the halls of justice because they have no recourse in a Federal or State court.

ERISA DOES NOT PROVIDE A RECOUPMENT REMEDY

This case is appropriate for rehearing because the issue it presents—the recoupment of monies already paid—is of extraordinary importance, both under ERISA's remedies provision, and in its impact on the ability of assignees of ERISA participants and beneficiaries who have been harmed by fiduciary withholding and recoupment without any recourse in a court of law.

The Second Circuit has decided an important question of federal law affecting ERISA assignees that has not been, but should be, settled by this Court. The recoupment permitted in this case has created a precedent whereby Appellee can, and has, undertaken an action of downcoding all claims submitted by Appellants to it without regard to whether the patient encounter satisfied the AMA code selection criteria. The absence of any reference to, or support under, ERISA in either the District Court or the Sec-

ond Circuit's decision has opened the door for summary downcoding and recoupment without Appellee being inconvenienced by document reviews or claim denial notifications and appeals as required by the ERISA statutes. In fact, other than this case, there are no cases in the Second Circuit in which equitable restitution has been awarded to a plan fiduciary for a disputed overpayment to a health care provider. *See Vacca v Trinitas Hospital*, 2006 WL 3314637 (E.D.N.Y. Nov. 14, 2006)

NATIONAL IMPLICATIONS

The ruling of the Second Circuit permits fiduciaries to ignore their statutory obligations, injure assignee physicians, and evade liability. Assignee physicians are thus left without a remedy against fiduciaries who have committed serious violations of ERISA's provisions, in particular ERISA's claims procedure.

A cursory review of the cases suggests the range of injuries that could go unredressed if the Second Circuit's decision remains standing given the number of health plans in the United States. Under the present ruling, ERISA plans may completely ignore the ERISA claims procedures for denial of claims from medical providers, and participating providers in particular. Plans, on the other hand, have developed a profitable business entity in its relationship with contracted physicians, and executed by committees created in the name of fraud and abuse on the basis of self-prescribed fiduciary authority, which is beyond the scope of current federal current law, and is now legalized by the Second Circuit's ruling. It is respectfully submitted that Congress did not anticipate this unprecedented scam which has not been fully disclosed to physicians or members participating under the health plan.

This case shows that as a result of unclear guidelines from the United States Supreme Court, the Second Circuit and several other circuits, have applied an arbitrary and capricious standard of review to the illegal actions of fiduciaries, and have permitted Funds like Appellee to create a system of review that is not only contrary to ERISA but is also unprecedented. This unfettered discretion permits Appellee to ignore federally mandated guidelines which are set forth in ERISA's Claims Procedures while engaging in and its overpayment recoupment scheme. This case represents the unspoken power that has been vested by the Second Circuit into Appellee and other health plans whereby an internal mathematical review system is substituted for documentary review in order to determine the validity of a physician's CPT code selection.

CONCLUSION

WHEREFORE, Appellants respectfully request that the Petition for Rehearing be granted.

Respectfully submitted,

DEVERAUX L. CANNICK, ESQ.
AIELLO & CANNICK
Counsel of Record
69-06 Grand Avenue
Maspeth, New York 11378
718-426-0444

ATTORNEY CERTIFICATION

Deveraux Cannick certifies as follows:

1. This Petition for Rehearing is restricted to the grounds specified in Rule 44.2.

2. The Petition for Rehearing is presented in good faith and not for delay.

Deveraux Cannick, Esq.
Attorney for Appellants

PLAINTIFF'S EXHIBIT 2

[HANDWRITTEN OVER AN IMAGE AT BOTTOM]
Getting Your Benefits

IN THIS SECTION

GETTING YOUR HEALTH CARE BENEFITS

- YOUR ID CARDS
- FILING A CLAIM FORM
- FEE NEGOTIATION PROGRAM
- QUALITY CARE ASSESSMENT

FILING FOR DISABILITY BENEFITS

FILING CLAIMS FOR OTHER BENEFITS

WHEN BENEFITS MAY BE WITHHELD OR DENIED

WHAT IS NOT COVERED

ADDITIONAL PROVISIONS

YOU CAN APPEAL

RESOURCE GUIDE

Who to Call

Member Services Department
212-307-7500

- If you have any questions regarding your ID cards
- If you need any claim forms
- If you have questions about completing your claim form

- For more information about the Fee Negotiation Program when you use non-participating providers
- If you have any questions about what is not covered by the Fund
- If you have any questions about the processing of your claim
- If you need information on appealing your claim

[IMAGE OF A CLERK BY A COMPUTER SCREEN]

GETTING YOUR HEALTH CARE BENEFITS

YOUR ID CARDS

When you become eligible for benefits, the Fund will send you a **Health Service ID card**.

If you are participating in the Member's Choice program, the Fund will also send you a Member's Choice **card**.

You may need these cards whenever you:

- Go to the doctor
- Go to the hospital
- Get a prescription filled.

FILING A CLAIM FORM

A claim form needs to be filled out and sent to the Fund so that:

- Your doctor or health care provider can be paid

or

- You can be reimbursed if you paid your doctor or health care provider.

If you use a participating provider, your doctor, hospital or health care provider will send the claim form to the Fund.

If you use a non-participating provider, you need to send your claim form to the Fund.

PROMPT, COMPLETE CLAIMS CAN BE PROCESSED FASTER

Get a Claim Form Before You Go to See Your Provider

Claim forms are available at the Fund office or by calling the Members Services Department at 212-307-7500.

If you use participating providers, they will have claim forms at their office.

- **Print Your Information**

Your claim can be processed faster if your form is filled out completely. Clearly print all the information requested:

- The member's name, address, and social security number

and

- The patient's name and birth date.

- **Have Your Provider Complete His or Her Section**

Your doctor, hospital or health care provider has to provide the Fund with information about your care, including:

- The date of the visit
- A list of services provided
- Diagnosis.

He or she needs to sign and date the form.

- **Sign the Assignment of Benefits Section**

If you want the Fund to reimburse your provider, you must sign the Assignment of Benefits statement on your claim form. This way, you are giving the Fund your consent to have the payment sent to your doctor, hospital or health care provider.

Note: The assignment feature of the Fund is only for payment of your benefits to providers. There is no further liability for any claim by any provider or third party and no such claims may be brought against the Fund.

- **Send Your Claim To The Fund**

It is very important to send your claim form to the Fund promptly:

Disability claims must be filed **within 30 days** of the start of your disability

All other claims must be filed **no longer than 90 days** after the services were provided

Life insurance and AD&D claims must be filed **no longer than one year** after the date of death or loss.

The Plan Administrator, at its sole discretion, may allow a claim to be filed late due to extenuating circumstances. But, the Fund will not pay claims filed *more than one year* after the service or treatment is provided.

QUALITY CARE ASSESSMENT

Your Fund is concerned about the quality of the care you and your family receive.

If our medical or dental advisor has questions about your claim, the Fund may send it to an independent spe-

cialist to review. In some cases, the Fund may require that you be examined by a specialist chosen by the Fund.

There is no cost to you for this consultation.

PHYSICIAN FEE NEGOTIATING PROGRAM

It's hard to discuss fees with your doctors or other health care providers. But when you use a non-participating provider, you may have a high out-of-pocket cost. Your Fund may be able to help.

To Get Help from the Fund

When you use a non-participating provider:

- Fill out your claim form
- Ask your provider to accept Assignment of Benefits.

Through the Fee Negotiation Program, the Fund will negotiate with your doctor and try to reduce or eliminate your out-of-pocket cost.

In many cases, doctors have accepted the Fund's reimbursement as full payment for your care. In other cases, the Fund was able to reduce members' out-of-pocket cost, even though they still had to pay part of the bill.

There is no guarantee that the Fund will be able to cut your out-of-pocket expenses. Therefore, we urge you to use a participating provider.

WHEN BENEFITS MAY BE WITHHELD OR DENIED

It is important that you provide the Fund with all the information, documents or other material it needs to process your claim for benefits.

The Fund may be unable to process your claim if you, your spouse or your children:

- Do not repay the Fund for benefits that you were not entitled to receive
- Do not sign an agreement (or comply with such an agreement) to repay the Fund in the case of legal claim against a third party
- Do not sign the Assignment of Benefits authorization when you want your benefits paid directly to your provider
- Do not allow the disclosure of medical information, medical records or other documents and information when requested by the Fund.

FUND'S RIGHT TO CONFIRM CLAIMS

Before paying any benefits, the Fund may require that:

You, your spouse or your children be examined by a doctor or dentist selected by the Fund as often as required during the period of the claim

An autopsy be performed to determine the cause of death, except where prohibited by law.

[IMAGE OF A WOMAN HOLDING A BABY]

WHAT'S *NOT* COVERED

In addition to the various exclusions set forth elsewhere in this booklet, the Fund does not cover:

- Charges in excess of the Fund's Schedule of Allowances

- Charges for services provided and supplies or appliances used before you, your spouse or your children became eligible for Fund coverage
- Charges for services covered under any mandatory automobile or no-fault policy
- Charges related to any work-related accidental injuries or diseases which are covered under Workers' Compensation or comparable law
- Charges for care resulting from an act of war
- Charges related to an illness or injury that was deliberately self-inflicted or that resulted from the person participating in an illegal act
- Charges for services or materials which do not meet the Fund's standards of professionally recognized quality
- Charges that would not have been made if no coverage existed or charges that neither you nor any of your dependents are required to pay. For example, the Fund will not pay for services provided by members of your or your dependent's immediate family.
- Charges made by your provider for broken appointments
- Charges for in-hospital services that can be performed on an ambulatory or outpatient basis
- Charges for treatment performed only for cosmetic purposes, except to remedy a condition that results from an accidental injury which occurred while covered by the Fund
- Charges for experimental or unproven procedures, services, treatments, supplies, devices, drugs, etc. (*see definition on page 107*).
- Charges for services, treatments and supplies covered under any other insurance coverage or plan, or

under a plan or law of any government agency or program

- Charges for services that are not FDA approved for a particular condition
- Charges that are unreasonable, excessive, or that are beyond the provider's normal billing rate.
- Charges for services that are not covered by the Fund
- Charges for services that are not medically necessary in the judgement of the Plan Administrator
- Charges related to interest, late charges, finance charges, court or other legal costs
- Charges related to programs for smoke cessation, weight reduction, stress management and other similar programs which are not provided by a licensed medical physician or not medically necessary
- Charges for claims submitted more than 12 months after the date of treatment
- Charges related to an illness or injury resulting from the conduct of another person, where payment for those charges is the legal responsibility of another person, firm, corporation, insurance company, payor, uninsured motorist fund, no-fault insurance carrier or other entity.

ADDITIONAL PROVISIONS

- Nothing in this booklet shall be construed as creating any right in any third party to receive payment from this Fund.
- Payments shall not be made to a person who is:
  - A minor (under age 18)
  - Unable to care for his or her affairs due to illness, injury, or incapacity.

Instead, the payment shall be made to a duly appointed legal representative or to such person who, in the judgement of the Plan Administrator, is maintaining or has custody of the person entitled to payments.

- No legal action may be brought against the Fund or the Trustees until all remedies under the Fund have been exhausted, including requests for Administrative reviews or appeals.
- Payments made by the Fund which are not consistent with the Plan—as stated in this booklet or as it may be amended—must be returned to the Fund.
- No benefit payable under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge.

Any action by way of anticipating, alienating, selling, pledging, encumbering or charging the same shall be void and of no effect. Nor, shall any benefit be in any manner subject to the debts, contracts, liabilities, engagements, or torts of the person entitled to such benefit.

Notwithstanding the foregoing, the Fund shall have the power and authority to authorize the distribution of benefits in accordance with the terms of a court order that it determines is a qualified medical child support order, as required by applicable Federal law.

YOUR RIGHTS ARE PROTECTED— YOU CAN APPEAL

If your entire claim, or part of your claim is denied, you have the right to appeal.

Any and all claims by you, your spouse/domestic partner, your children, your beneficiaries or third parties against the Fund, must first be reported to and reviewed

by the Plan Administrator before they shall become the subject of litigation in either State or Federal Court.

APPEALING DISABILITY CLAIMS

You will receive a notice of rejection if:

- Your claim for disability benefits is denied

or

- You are not paid for the full period of disability you claimed.

The reason for the rejection will be stated.

To appeal this ruling, you must:

- Follow the directions that are on the back of the rejection notice (DB-451). If you do not have this form available, contact the Fund at 212-307-7500.

and

- *Within 30 da*ys, send the request for a review in writing to the applicable State agency.

Your claim will be reviewed and you will receive a written notice of the decision from the State.

If your appeal is denied, you may request an Administrative Review from the Fund, by sending a letter to the Fund *within 60 days.*

APPEALING ALL OTHER BENEFIT CLAIMS

When you claim is fully denied, partially denied or your benefits have been reduced, you will receive a written notice from the Plan Administrator *within 90 days* from the date your claim is received by the Fund office.

The reason why your benefits have been denied or reduced will be given and you will be told of the specific provisions of the Plan on which the decision is based.

In special circumstances, more than 90 days may be needed to process your claim and make a decision. In this case, you will be sent a notice of an extension *within 90 days* from the date your claim is received, stating why additional time is needed. If your claim is denied, you will be sent a notice *within 180 days* from the date your claim is received.

If you do not receive a notice of denial or notice of an extension within 90 days from the date your claim is received, you should consider your claim denied and request an appeal.

To appeal:

- **You must write to the Plan Administrator within 60 days** of the date you receive the notice of denial, asking for a review of the decision
- You, or your authorized representative, have the right to request a review of documents pertinent to your claim and to send written comments or questions to the Plan Administrator
- If your claim is denied following this administrative review, you will receive a written notice informing you of the decision
- You can then make a final appeal directly to the Appeals Committee of the Board of Trustees.

MAKING A FINAL APPEAL

Send a letter to the Plan Administrator **within 60 days** of the administrative review decision

Your appeal will be considered by the Appeals Committee of the Board of Trustees. If you elect to do so, you will be permitted to appear personally before the Appeals Committee, along with a representative of your choice

You should receive a written decision from the Appeals Committee usually **within 60 days** after the Committee receives your request for a review. The notice will give the specific reason(s) for the decision and the specific provisions of the Plan on which the decision is based

If extra time is needed to make a decision, you will be sent a written notice of extension. The review will take **no longer than 120 days** after the Committee receives your request for a review.

Written notice of the extension shall be furnished to you before the extension begins. If you do not receive a decision or a notice of an extension within the appropriate period, you should consider your appeal to be denied on review.

All decisions of the Appeals Committee shall be in writing and shall be final and binding on all parties affected by it.

AUTHORITY OF THE PLAN ADMINISTRATOR

Notwithstanding any other provision in the Plan, and to the full extent permitted by ERISA and the Internal Revenue Code, the Plan Administrator shall have the exclusive right, power and authority, in its sole and absolute discretion:

- To administer, apply, construe and interpret the Plan and any related Plan documents

- To decide all matters arising in connection with entitlement to benefits, the nature, type, form, amount, and duration of benefits and the operation and administration of the Plan
- To make all factual determinations required to administer, apply, construe and interpret the Plan (and all related Plan documents).

Without limiting the generality of the statements above, the Plan Administrator shall have the ultimate discretionary authority to:

(i) Determine whether any individual is eligible for any benefits under this Plan;

(ii) Determine the amount of benefits, if any, an individual is entitled to under this Plan;

(iii) Interpret all of the provisions of this Plan (and all related Plan documents);

(iv) Interpret all of the terms used in this Plan;

(v) Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms;

(vi) Decide questions, including legal or factual questions, relating to the eligibility for, or calculation and payment of, benefits under the Plan;

(vii) Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other related Plan documents; and

(viii) Process and approve or deny benefit claims and rule on any benefit exclusions.

All determinations made by the Plan Administrator (or any duly authorized designee thereof) and/or the Appeals Committee with respect to any matter arising

under the Plan and any other Plan documents shall be final and binding on all parties.

[National Benefit Fund logo]

For Health and Human Service Employee:

National Benefit and Pension Funds: (646) 473-9200
Greater New York Benefit Fund:• (212) 541-9150
• Pension Fund: • (646) 473-8666
Home Care Employees Benefit and Pension Funds:
• (646) 473-9200
Home Health Aide Benefit Fund: (646) 473-7470

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330 West 42nd Street, New York, N.Y. 10036-6977
• www.1199nbf.org

Via Overnight Mail

March 11, 2004

Clinton Sewell, MD
Caricare Medical Services
230-11 Linden Boulevard
Cambria Heights, N.Y. 11411

Dear Dr. Clinton:

The 1199 National Benefit Fund has been in contact with you regarding your billing practices, which have resulted in overpayments from the Fund. You have responded with information that does not provide an acceptable response to our reviews. The basis for our reviews is the Current Procedural Terminology (CPT 2004) from the American Medical Association, which are the acceptable criteria for most payers. I have enclosed the section on Evaluation and Manage-

ment. We have also included a detailed listing of Provider Claims Detail that has bearing on our review.

Since you were unwilling to resolve this as we first suggested, in a continued review of your billing patterns and practices, your payments have been withheld pending resolution of this matter.

In further effort to resolve this matter, we are requesting that you send us a legible photocopy of the medical record for each of our Members listed on the attached sheet. In order to expedite the review process, be sure to include all relevant information (including but not limited to: history and physical exams, progress notes, laboratory results, radiological reports/findings, for all visits during the period of May 1, 1999 through March 31, 2003. Please send these records within fifteen (15) days of receipt of this request.

The Fund considers upcoding to be a very serious violation and it intends to pursue these situations vigorously. If I do

not receive your records within fifteen (15) days, we will have to pursue all available remedies to resolve this.

Sincerely,

/s/ Ruth Antoniades
Ruth Antoniades UDC
Special Program Coordinator

Encl.

cc: Frank Hagen, Director
Kate Botley, Assistant Director
Celia Shmukler, M.D.

All of these Funds are jointly administered, benefits are subject to each Fund's Summary Plan Description (SPD) and the discretion of the Trustees of that Fund.